DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue, N.W.
WASHINGTON, DC 20307-5001

WRAMC Regulation
No. 40-109

09 September 2002

Medical Services

PLAN FOR THE PROVISION OF PATIENT CARE

1. History.
This is the first publication of this document as an official Walter Reed Army Medical Center (WRAMC) regulation.

2. Purpose.

a. To define Walter Reed Army Medical Center's (WRAMC) plan for the provision of health care services to its beneficiary population.

b. To identify key elements and processes for the safe provision of patient care thus providing a synopsis of how patient care will be delivered.

c. To address the collaborative approach for patient care in concert with the organization's strategic plan, operational mission and available resources to perform that mission.

d. To establish responsibilities for patient care. Provides guidance on entry into the health care treatment system, assessment, treatment, transfer, education and discharge planning of patients along the continuum of care.

e. To provide information on patient rights, organizational ethics, and patient safety.

3. References

a. AR 40-3, Medical, Dental, and Veterinary Care, 28 January 2002.

b. WRAMC Regulation 40-68, Performance Improvement, Patient Safety, Risk Management Plan, I July 2002.

c. AR 40-68, Quality Assurance Administration, 20 December 1989.

d. WRAMC Regulation 40-104 Comprehensive Screening, Assessment, and Reassessment of Patients, 1 July 2002.

e. AR 40-66, Medical Record Administration and Healthcare Documentation, 3 May 1999.

f. WRAMC Regulation 40-90 Hospital Patient/ Family Education, 23 June 2002.

g. WRAMC Regulation 40-82 Medication Ordering, Administration and Documentation, 20 June 2002.

h. WRAMC Regulation 40-614 Interdisciplinary Discharge Planning Program, 3 July 2002.

i. WRAMC Pamphlet 40-10 Advanced Directives, 1 July 2002.

j. WRAMC Pamphlet 40-11 Bill of Rights, 1 May 2002.

k. WRAMC Regulation 40-96 Informed Consent, 28 June 2002.

l. WRAMC Regulation 40-3 Withholding and Withdrawing Life Sustaining Treatment (WLS), including Do Not Resuscitate (DNR) 19 April 2002.

m. WRAMC Pamphlet 608-19 Management of Alleged Child/Spouse/Elder Abuse or Neglect Case, 26 March 2002.

n. WRAMC Regulation 40-25 Walter Reed Army Medical Center Bylaws, 2 May 2002

o. TRICARE Website : http://www.tricare.osd.mil/

p. Walter Reed Medical Center Website: http://www.wramc.amedd.army.mil/

4. Overview

a. TRICARE is the Department of Defense (DoD) healthcare delivery system. TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE brings together the health care resources of the Army, Navy and Air Force and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations. TRICARE Prime is designed on a health maintenance organization (HMO) model. The Walter Reed Health Care System is located in TRICARE Region 1. Each TRICARE Region's Lead Agent selects the managed care contractor that will provide all external sources of medical care for its beneficiary population. The contract requires that these external sources of medical care meet national accreditation standards. Comprehensive information regarding TRICARE and its health benefit options are available for patients and providers on the TRICARE website: http://www.tricare.osd.mil/.

b. As a Department of Defense (DoD) Army owned and operated military medical treatment facility (MTF), Walter Reed Army Medical Center (WRAMC) with executive agency over the clinics at the Pentagon, Arlington Annex and at Fort McNair, has responsibility for providing comprehensive medical care required for eligible beneficiaries. Walter Reed Army Medical Center is the Army's largest healthcare facility, and one of the largest in the Department of Defense. Walter Reed Army Medical Center consists of an inpatient facility with 256 operating beds and 44 outpatient clinics. Walter Reed Army Medical Center's immediate health service area in the metropolitan Washington, D.C. (National Capital Area - NCA) covers a radius of about 40 miles. Walter Reed Army Medical Center is part of the Walter Reed Health Care System (WRHCS) that also includes DeWitt Army Community Hospital at Fort Belvoir, Va.; Kimbrough Ambulatory Care Center at Fort Meade, Md.; and their satellite clinics. Patients and providers may obtain detailed information about the services and resources available at WRAMC by visiting the WRAMC website at http://www.wramc.amedd.army.mil/ .

c. In the NCA there are 404,000 military beneficiaries of whom approximately 265,000 are enrolled in TRICARE Prime. An estimated 58,000 of the beneficiary population in the NCA are aged 65 years or older. WRAMC provides specialty care referral services for over 144,000 TRICARE enrolled beneficiaries in the WRHCS as well as the 65,000 enrolled at the National Naval Medical Center in Bethesda, Maryland and the Malcolm Grow Medical Center at Andrews Air Force Base, Maryland.

d. Walter Reed Army Medical Center and the WRHCS are achieving national standards of care through patient-centered technology and outcomes-focused disease management programs in the following areas: diabetes mellitus, pediatric asthma, breast cancer, chronic obstructive pulmonary disease, congestive heart failure, cardiovascular risk reduction, and hepatitis C. Soon WRAMC will be undertaking new initiatives in women's health and secondary stroke prevention.

The WRAMC Outcomes Management Initiative (soon to be known as “Health *e* Forces”) capitalizes on advances in wellness, prevention, and disease outcomes management to support maximum quality of life and health for our beneficiaries. This new approach to health care actively partners patients with their primary care provider and specialists to assess their disease-specific concerns. Outcomes management enables health care professionals to be accountable for a given patient cohort's health status and to compare their performance to national norms as applicable (e.g. Diabetes Quality Improvement Project [DQIP] benchmarks for patients with Diabetes Mellitus.) Nationally recognized validated surveys are used to allow patients to quantify their health status, disease experience and quality of life. Medical decision-making is supported by information-rich, automated scorecards that contain links to clinical practice guidelines and evidence-based medicine. The Outcomes Management Initiative management strategy utilizes specialized, disease-specific databases that are supported by the Integrated Clinical Database (ICDB). The ICDB is a technically sophisticated product that leverages existing information systems to merge healthcare data from disparate sources to one readily available data center.

5. Responsibilities

The Commander is the Chair of the WRAMC Governing Board to which the Executive Committee of the Medical and Administrative Staff (ECMAS) reports. The Deputy Commander for Clinical Services (DCCS), Deputy Commander for Administration (DCA), Deputy Commander for Nursing (DCN), and the WRAMC Sergeant Major participate in the organizational leadership, to include membership on WRAMC’s ECMAS and the Governing Body. All are involved in data -driven corporate decision-making and participate in discussions pertaining to WRAMC’s mission, budget, resource management, access, performance improvement and patient safety initiatives to support the delivery of quality health care.

a. The Commander:

(1) Assures the framework exists for planning, directing, coordinating, providing, evaluating, and improving the safe delivery of health care services that are responsive to our patient population and community needs.

(2) Ensures services are planned based on the population served, the mission of WRAMC, and identified patient needs.

(3) Ensures that resources are available to fulfill the necessary requirements. Reviews resourcing recommendations made by the DCCS, DCA, DCN, and the Department/Service Chiefs in conjunction with the vision, mission, strategic goals, business plan, and budget.

b. The Deputy Commander for Clinical Services (DCCS):

(1) Serves as the Chief of the Medical Staff.

(2) Orchestrates the provision of patient care services to designated beneficiaries. This includes timely access to patient-focused care with competent and safe treatment by professional and caring staff. This is achieved through the development of a seamless healthcare network achieved by integrating clinical and administrative departments as well as emphasizing interdisciplinary coordination and collaboration in care delivery.

(3) Assures the services provided are monitored and continually improved so they fulfill the identified needs of the beneficiary population. Quality services will be delivered in a timely, safe, cost-effective manner, to the satisfaction of the customer, with the desired/expected outcome.

c. The Deputy Commander for Administration (DCA):

(1) Ensures administrative and support services are provided for the Medical Center.

(2) Coordinates and integrates the administrative and support activities to sustain the clinical staff in the provision of quality patient care services.

(3) Provides a safe, functional, supportive, and effective environment for patients, staff member, and other individuals in the hospital.

d. The Deputy Commander for Nursing (DCN):

(1) Provides direction and leadership for all nursing activities within the Medical Center. Advises the Commander, DCCS, DCA and other leadership staff on all matters pertaining to nursing personnel, nursing care, and nursing services across all department/divisions.

(2) Ensures standards of nursing practice and patient care standards are implemented all areas providing nursing care.

(3) Ensures appropriate number and skill mix of nursing staff are available and qualified to provide safe, effective patient care.

(4) Ensures current research findings are integrated into policies and procedures guiding the delivery of nursing care as well as standards of patient care and nursing practice.

e. The Chiefs of Clinical Department/Services:

(1) Participate in the development and implementation of policies and procedures regarding the delivery of health care to the patient population.

(2) Ensure patients are provided treatment in a coordinated and collaborative manner within the Walter Reed Health Care System and its referral network.

(3) Implement and maintain an active performance improvement program within the department/service and participate in the interdisciplinary performance improvement/patient safety activities to improve overall organizational performance.

(4) Maintain a work climate focused on patient and staff safety to include fostering a work environment conducive to non-retributional error reporting.

(5) Determine the required qualifications and competencies of department /service personnel and recommend to the DCCS, DCN, and DCA the number of personnel needed to provide quality care/service. Recommends space allocation and other resources required to provide the treatment services adequately.

(6) Provide appropriate orientation, continuing education, and ongoing competency assessment for all staff within the department/service to include: the knowledge and skills required to perform his/her duties and responsibilities; the effective and safe use of equipment in his/her activities; and the prevention of contamination and transfer of infection.

(7) Participate in the allocation of resources.

6. Entry into the Health Care System

a. Primary care is provided in multiple portals with beneficiaries assigned to a provider/team. Each patient enrolled in TRICARE Prime or Plus is assigned a specific primary care manager (PCM) who manages their care and provides referrals for specialty care.

b. Specialty care is provided on a referral basis within WRAMC or other military/civilian facilities within our network as appropriate. Medical care is provided to non-enrolled beneficiaries on a space available basis. Emergency care is available for anyone.

c. Consultation with Specialty Care Services. When the patient care requirements exceed the scope of practice of the PCM, a consultation is made to the specialty care services. If the patient cannot be seen within the pre-established TRICARE Prime access standards the patient may then referred to the TRICARE Prime Network or another military treatment facility.

d. Managed Care Options. If the health care needs of a patient exceed the scope of WRAMC primary or specialty services, the PCM and/or health benefits advisor will consult with the patient and jointly determine whether it is in the patient's best interest to be referred to another military treatment facility having a broader scope of services or be referred to a local TRICARE Network or health care facility. Coordination is maintained with those external sources of care to determine the most expedient time to return the patient to the care of the Walter Reed clinical staff.

e. Emergency Care Services. Emergency medical care is available 24 hours a day, seven days a week, by the Walter Reed Emergency Services. Ground and air patient transportation services are provided to designated referral health care facilities for those patients whose treatment requires transfer.

7. Assessment of Patient's Health Care Needs

GENERAL NOTE: Primary Care health care providers will perform an initial assessment of the patient to include, at a minimum, the physical (including pain), psychological (including cognitive and communicative skills or development), and social state of the patient. The scope and intensity of further assessment of the patient is then based upon his/her diagnosis, the treatment setting, the patient's desire for treatment and the patient's response to previous treatment. These factors will also determine the requirement for additional in-depth assessment, incorporating such specialties as Nutrition Care, Social Work Services, Physical and Occupational Therapy and/or diagnostic testing. The various disciplines will conduct assessments in accordance with their established specialty standards and service policies. Those specialty services will also ensure interdisciplinary review of their assessments for the creation of a comprehensive and supportive plan of care. The age-specific nature of the patient's medical care needs will be considered during the patient's assessment. Walter Reed Army Medical Center Regulation 40-104 Comprehensive Screening, Assessment, and Reassessment of Patient, outlines the screening and assessment polices and procedures for all patient care areas.

a. Outpatient Primary Care Assessment Process. For patients who are receiving their medical care in an outpatient setting, a Master Problem List is maintained in their outpatient treatment record (or electronically). Upon each visit, the health care provider reviews the Master Problem List and obtains a chief complaint, along with vital signs, and pain, nutritional, functional status and learning needs screenings. These data are used to identify patient needs for further assessment, care, or referrals for additional services. The need for a reassessment is dictated by the patient's clinical condition and follow-up care is reflected in the outpatient treatment record.

b. Outpatient specialty care assessment processes will be in accordance with their established specialty standards and service policies. Upon each visit, the health care provider reviews the Master Problem List , updates if necessary, and obtains a chief complaint, screens for pain and performs additional patient screening procedures as appropriate.

c. Inpatient Assessment Process:

(1) An initial assessment will be completed within 24 hours of admission to WRAMC. The initial assessment will be conducted by physicians and registered nurses (RNs) and will include, at a minimum, an evaluation of the physical parameters, psychological status, social status, pain status, functional status and discharge planning needs. The Clinical Information System (CIS) Nursing Admission Note provides criteria for screening patients for nutritional, functional, behavioral health and discharge needs. In addition patients are assessed for safety concerns such as falls risk and skin breakdown potential and care is planned to ensure a safe patient environment. The initial assessment must be a collaborative effort between the disciplines, reducing duplication of effort and enhancing the collection of quality data. The assessment data are evaluated and a collaborative plan of care is developed. Each discipline involved in the care of the patient is expected to document their priority of care in their progress notes that will convey to the integrated documentation template that is included in each discipline's progress note. The interdisciplinary team involved in the care of the patient reviews notes from each discipline and utilizes the information for continuity and efficiency in developing the plan of care. The identification and prioritization of health care needs is mutually determined with the involvement of the patient, family and/or significant others.

(2) The plan of care may indicate a need for additional assessment based upon the diagnosis, screening criteria, and identification of discharge planning needs. The Physician will initiate a consultation to Physical Therapy, Occupational Therapy, Speech Therapy and/or Behavioral Health if any screening criteria were positive for the patient. The physician is responsible for notifying the appropriate service of the need for consultation within 24 hours of the identification of the need for referral. Nutrition Care, Social Work Services , The Care Continuum Management Service and Pharmacy Services will automatically evaluate any positive screening for a patient. Each of these services will assess patients within an appropriate time frame as per the individual service's plan for assessment and reassessment of patients. All Physicians may initiate consults to specialty services for intensive and/or multidisciplinary assessments and participation in the plan of care. The specialty service will conduct their assessment and collaborate in designing of the plan of care and evaluating patient progress. Specialty disciplines may, in turn, consult additional specialties based upon their evaluation.

(3) Inpatient reassessments will be conducted by the licensed independent practitioner and the registered nurse every 24 hours at a minimum and whenever there is a significant change in the patient's status. Evaluation of the patient's progress toward treatment goals will result in an appropriate revision of the plan of care. Specific patient populations may be evaluated or reevaluated more often based on unit specific guidelines.

d. Assessment of victims of alleged or suspected abuse or neglect. The clinical staff, outpatient and inpatient, will demonstrate extra sensitivity in the assessment of patients who are alleged or suspected to be victims of abuse or neglect. The assessment will consider those age and gender specific factors which are unique to each incident. The plan of care will include a priority referral to the Department of Social Work, who will provide comprehensive investigation services, family support and/or protective services. Assessment and treatment will be provided in accordance with WRAMC Pamphlet 608-19 Management of Alleged Child/Spouse/Elder Abuse or Neglect Case.

8. Treatment of Patient's Health Care Needs

a. Medication Therapy:

(1) The Medical Staff utilizes the interdisciplinary Pharmacy and Therapeutics Committee (PTC) to evaluate, recommend, and select all medications that are provided by Walter Reed and its outlying clinics.

Medications are selected based upon their proven clinical efficacy, patient need, safety, cost and local practice and are added to the medication list in the Composite Healthcare Computer System (CHCS). Copies of the medication list are available in CHCS. The activities of the PTC are governed by AR 40-3 Medical, Dental, and Veterinary Care and are approved by the Commander.

(2) Pharmacy Standing Operating Procedures address the procedures and the environment for medication preparation and dispensing, storage of medications, and personnel safety. All areas where medications are stored, prepared, and dispensed are inspected monthly.

(3) In the area of medication administration, the provisions of WRAMC Reg 40-82 Medication Ordering, Administration and Documentation, guide the clinical staff. The intent is to safely and efficiently administer medications by ensuring that the correct medication is ordered, that the correct medication is given, and that the medication is given by a person licensed and/or trained to do so. The PTC exercises control over the dispensing of all new, high risk, high volume, investigational, or experimental medications by restricting the authorization to prescribe to specifically qualified practitioners. Evidence of the processes mentioned in this section is present in the minutes of the PTC and in the patient's medical record.

(4) Medications are monitored for their effectiveness and the results are noted in the patient's medical record. All adverse drug reactions are reported to the Pharmacy Department for further investigation.

(5) The hospital provides parenteral nutrition services to appropriate patients following a complete assessment by their treating physician and, if necessary, in consultation with the hospital's Nutrition Service. Guidelines for the ordering, preparation, and dispensing of parenteral nutrition are found in the Policies and Procedures section of the Hospital Formulary.

b. Operative/Invasive Procedures:

(1) Selection of the appropriate procedures. Each service that performs operative and/or invasive procedures will follow recognized assessment guidelines by which the appropriate procedures are determined for each individual patient.

(2) Preparation of the patient. The medical staff will ensure the patient plays an active role in the selection of the procedure through documented discussion of the invasive procedure and/or surgical options available and the risks associated with each option. The pre-anesthesia assessment will be fully documented in the patient's medical record, as will be the nursing care plan and the plan for safely managing the patient during and after the procedure.

(3) Monitoring the patient during and after the procedure. During the procedure, the patient's physiological status will be measured and assessed. Post procedure monitoring will include the following: patient's physiological and psychological status, pain status, pathological findings, Intra-venous (IV), drugs, and blood or blood components administered, and any unusual complications.

(4) Discharging the patient from the service or setting. The medical record clearly documents the assessment of all patients upon their arrival in the post-anesthesia recovery area and prior to their discharge. Discharge from the post-anesthesia recovery area is accomplished by a qualified licensed, independent practitioner or by using hospital-approved criteria.

9. Transfer of Patients

Transfer of patients includes both internal and external procedures. Patients may be transferred from one patient care unit to another, from one clinical service to another, or from one licensed independent practitioner to another. Patients may be transferred from or to Walter Reed from civilian or military facilities or health care providers.

10. Education of Patient and Family

GENERAL NOTE: The goal of patient and family education is to improve patient outcomes by promoting healthy behavior, and appropriately involving the patient in his/her health care and care decisions. Patient/family education activities are conducted in accordance with WRAMC Regulation 40-90 Hospital Patient/Family Education.

a. Patient and family education should:

(1) Facilitate the patient and family's understanding of the patient's health status, health care options, and consequences of options.

(2) Encourage participation in decision making about consequences of options selected.

(3) Enhance patient safety and potentially reduces medical errors by promoting awareness of the safety hazards while receiving care.

(4) Increase patient and family's potential to follow the therapeutic health care plan.

(5) Maximize care-giving skills.

(6) Increase the patient's/ family's ability to cope with the patient's health status, prognosis, and out-come.

(7) Enhance the patient's/ family's role in the continuum care.

(8) Promote a healthy lifestyle.

b. Patient/family education responsibilities. The health care team will share the responsibilities for patient/ family education. The hospital Patient/Family Education Committee provides guidance for this.

c. Determination of educational needs of patient and family. The clinical staff (inpatient and outpatient) utilizes a multidisciplinary approach in the assessment of the educational needs of each patient and their family.

d. Presentation of patient/ family education. Just as the assessment of the patient's and their family's educational needs are made through the interdisciplinary coordination of physicians, nurses, dietitians, rehabilitation specialists, and appropriate ancillary clinical staff, the presentation of that education is also provided as a interdisciplinary activity.

e. Evaluation of effectiveness of patient and family education. When the members of the treatment team provide education to the patient and/or their family, they will thoroughly document that education and training in the patient's medical record. They will make every attempt to verify the patient's and family's level of understanding by soliciting feedback from them and documenting that feedback in the medical record. If the patient is transferred to another health care facility, the interdisciplinary team will forward a copy of the pertinent information to the receiving facility in order to enhance the continuity of quality care.

11. Discharge Planning

The discharge planning process will begin on admission for all patients and will continue through their actual discharge.

Walter Reed Army Medical Center Regulation 40-614 Interdisciplinary Discharge Planning Program, describes the staff's responsibilities toward discharge planning and outlines the procedures by which it is accomplished. As a military medical treatment facility, WRAMC often faces several unique requirements concerning the discharge of young unmarried soldiers who would normally live in a barracks environment or are located at other Army posts. Many of the activities of barracks life are not conducive to the needs for convalescence. For this reason, the hospital periodically maintains a convalescing patient on the hospital rolls longer than it ordinarily would, in order to facilitate the specific care needs for that patient.

12. Patient Rights and Organizational Ethics

GENERAL NOTE: Walter Reed Army Medical Center respects the rights of the patient and recognizes that each patient is an individual with unique health care needs. Because of the importance of respecting each patient's personal dignity, the hospital strives to provide considerate, respectful care that is focused on the patient's individual needs. The staff of WRAMC affirms the patient's right to make decisions regarding his/her medical care, including the decision to discontinue treatment, to the extent permitted by the laws of the District of Columbia. The hospital actively assists the patient in the exercise of his/her rights and works to inform the patient of any responsibilities incumbent on him/her in the exercise of those rights. The WRAMC Pamphlet 40-11 Bill of Rights, WRAMC Pamphlet 40-10 Advanced Directives, WRAMC Regulation 40-3 Withholding and Withdrawing Life Sustaining Treatment (WLS), including Do Not Resuscitate (DNR), and WRAMC Regulation 40-96 Informed Consent provide additional information related to items *a* through *f* below.

a. Education of the patient about their rights. Staff members having direct contact with patients and their families, must constantly consider themselves in the role of patient educator. They must recognize that the education includes information regarding their rights as patients and families. The scope of those rights is broad and is enforced by staff in every section of the hospital. These include the right to simple courtesy, to personal privacy, to confidentiality, to education about their health status, to participation in the treatment decisions being made, and to be allowed to make decisions to withhold or withdraw treatment. Patients' and family members' rights and responsibilities and information about advance medical directives/ living wills are provided to the patient upon admission to the hospital. Physicians, nurses, and administrative personnel all play critical roles to ensure that patients and their families understand their rights and those rights are respected.

b. Policy on Informed Consent. The hospital has identified several critical medical treatment related activities that warrant special attention by the staff as to:

(1) Essential education required by the patients and their families concerning impending treatment.

(2) Critical activities include, but are not limited to, receiving anesthesia, sedation, undergoing invasive procedures, receiving blood or blood products, undergoing certain laboratory and x-ray procedures, and leaving the hospital against medical advice. The hospital utilizes informed consent to ensure that the patient and their family are fully educated about the nature of, and the risks associated with, these critical activities. When the patient or their legal next-of-kin or guardian sign the forms, this indicates their informed consent to, or rejection of, the treatment being recommended by their medical team.

c. Personal Privacy. The hospital believes that in order to respect the individual rights of each patient, the personal privacy of each patient also needs to be respected. The nature of medical treatment in a health care setting often creates situations in which some patients feel uncomfortable because of their gender, age, spiritual, or cultural background. The staff will extend to all patients the utmost courtesy possible in keeping with the provision of the medical treatment that is required.

d. Confidentiality of Information. All information about a patient's medical condition and the treatment being provided is considered private and will not be released to any source without the patient's permission. As a matter of course, various clerical and administrative personnel must see a private medical record. This circumstance does not create any inherent right of access but is merely an extension of the physician's and the hospital's responsibility for proper preparation and processing of the record. All of these individuals have a professional and moral obligation to keep confidential information obtained from private medical records in the course of their work. Guidance regarding WRAMC policies regarding confidentiality is located in WRAMC Regulation 40-35.

e. Walter Reed Army Medical Center Regulation 40-3 Withholding and Withdrawing Life Sustaining Treatment (WLS), including Do Not Resuscitate (DNR), outlines the hospital's policy regarding the initiation and the maintenance of DNR orders in the medical records of those patients who have chosen to make such treatment decisions. The staff respects the patient's right to change their DNR decision at any time, if they are deemed competent to make such a decision. If the patient is not deemed competent or is a minor, the staff will respect the decisions of the next-of-kin or legal guardian in these matters.

13. Review Process/Evaluation.

a. Ongoing evaluation of health care delivery is a part of the Performance Improvement/Risk Management and Patient Safety Programs and continued compliance with our accreditation through the Joint Commission on Accreditation of Healthcare Organizations.

b. The plan for the provision of patient care is linked to the organization's strategic planning, mission and resource changes through the Governing Body of the Medical Center and the Command structure.

14. Staffing Standards

a. The Army Medical Command uses a mandated manpower determination tool called Automated Staffing Assessment Model (ASAM), Manpower requirements are determined based on historical production-type workload. The Table of Distribution and Allowances (TDA), is built on the historical workload based requirements and adjusted by workload and medical planning factors specific to this facility. Readiness factors are used for military clinical authorizations. Inpatient work centers use the average monthly inpatient census in combination with the Workload Management System for Nursing measuring patient acuity. Utilizing the ASAM model, existing TDA, historical and projected workload and subject matter expertise, the governing body leadership plans and defines the overall qualifications, competencies, and staffing necessary to meet the hospital's mission. (Note: The ASAM is undergoing revision to become a population based model utilizing historical measures, current clinical practice, research studies, practice outcomes, and subject matter experts.)

b. The leadership provides for competent staff through utilization of military, government civilian personnel system, and contractual arrangements. An initial assessment reviews an applicant's credentials and qualifications. Experience, education, and abilities are evaluated during orientation.

c. The leadership will provide for periodic competence assessment to assess staff members' continuing abilities throughout their association with the hospital.

d. The leadership creates a culture that fosters staff self-development and continued learning. Feedback about the work environment is necessary and is assessed formally and informally.

e. The leadership at the department, service, and unit levels will utilize combination of the above as well as individual unit/staff assessments to ensure appropriate staffing in their areas.

15. Staffing Effectiveness

In accordance with (IAW), with JCAHO Guidance, additional measures will be undertaken to assess inpatient staffing effectiveness. Direct (inpatient nurse staffing) and indirect (inpatient pharmacy staffing) patient caregiver human resource indicator data will be assessed for their relationships to patient-related clinical indicator data. Specifically, nursing care hours per patient day and nursing skill mix indicator data will be evaluated monthly in relation to nurse committed medication errors, nurse-detected medication near misses, and patient falls. Inpatient pharmacy skill mix data will be evaluated for its relationship to inpatient pharmacy medication dispensing errors. These staffing effectiveness analyses will be reported at the departmental and organizational levels. Nurse staffing and clinical indicator data will be reported at the individual nursing unit level, to the Nursing Leadership Committee, and the Executive Committee of the Medical and Administrative Staff. Pharmacy staffing and clinical indicator data will be reported at the Pharmacy QI / QA meeting and the Executive Committee of the Medical and Administrative Staff.

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DEPARTMENT OF MEDICINE
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Medicine (DoM) provides for the comprehensive non-surgical care of adult patients in both the inpatient and outpatient settings. The DoM comprises 11 Services: Cardiology; Dermatology; Emergency Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; General Medicine; Hematology-Oncology; Infectious Diseases; Nephrology; Pulmonary and Critical Care Medicine; and Rheumatology. Each Service maintains an individual Scope of Practice and Credentialing Guidelines.

2. Types and Ages of Patients.

Inpatient and outpatient tertiary referrals are made to WRAMC from throughout the National Capital Area, Northeast United States and Europe. All DoM Services provide medical services for adults and geriatric patients in their respective specialty areas. Specifics are detailed in the individual Services Scope of Practice and Credentialing Guidelines. Pediatric patients of all ages are cared for by the pediatric cardiologists of the Cardiology Service and the Dermatology Service. The Rheumatology Service operates a Juvenile Arthritis Clinic. The Emergency Medicine Service sees all pediatric emergencies when the Pediatric Clinic is closed.

3. Complexity of Patient Care Needs.

Patients are cared for in both the inpatient and outpatient settings. Walter Reed Army Medical Center inpatients, who are the responsibility of the DoM, are admitted to either the General Medicine Service (Ward 75 and 71), the Medical Intensive Care Unit (Ward 45B), Coronary Care Unit (Ward 40), the Intermediate care Unit (Ward 45C), or the Cardiology Step-down Unit (Ward 41). Within the Emergency Room, we also have a 2 bed chest pain unit. Consultations are performed for adult inpatients on all WRAMC Wards by all DoM Services. Outpatient complex medical evaluations are conducted in the Medical Evaluation and Treatment Unit. Some patients receive “principal” care in sub-specialty clinics when a disorder of one system dominates their health care needs. Outpatient sub-specialty consultation and care is provided by all DoM Services at WRAMC. Outpatient consultation in Cardiology, Pulmonary, and Gastroenterology are provided on-site at DeWitt Army Community Hospital. Dermatology consultations are provided at the Pentagon and Rader Clinics. Specialized care is also provided by the Coronary Artery Disease Reversal (CADRE) program and the Walter Reed Health Care System Diabetes Institute.

4. Meeting Patient’s Needs.

Patient needs are identified through periodic patient satisfaction surveys performed by the WRAMC Patient Representative’s Office by individual Services. Needs are also determined through consultation with other providers. Department of the Army and Department of Defense Health Affairs determine some minimal criteria for patient care services. Patient needs are discussed regularly at bimonthly Service Chief’s meeting and at an annual one-day DoM retreat. For patients who do not wish to use (or are unable to be accommodated within) the military health care system, the TRICARE and MEDICARE program provide a means of obtaining necessary services. If these are services that are necessary but cannot be provided by WRAMC, patients are referred to other military facilities or civilian hospitals. Such outside care is paid for by MEDICARE or TRICARE for eligible individuals. Walter Reed Army Medical Center, as a part of a comprehensive healthcare system within the National Capital Area, has instituted a one call admission system to facilitate the rapid transfer of patients to WRAMC.

5. Support Services.

The DoM receives support from a variety of WRAMC directorates, notably Directorates of Logistics, Contracting, Information Management, Patient Administration, Administration and Operations, Resource Management; the Civilian Personnel Office and the Medical Center Brigade. The Department of Nursing provides professional support and oversight for DoM nursing staff in the Emergency Room and clinics. While most personnel in the DoM are active duty military or Department of the Army GS civilian employees, we have a number of contract physicians, LPNs and PAs significantly within the Department of Medicine to support our patient care mission. A small but increasing number of clerical or support personnel are also contract rather than government employees. The DoM provides emergency medical services and ambulance services to the WRAMC community. Both are available 24 hours per day, 7 days per week.

6. Availability of Necessary Staff.

The DoM staffing is dictated by Medical Command manning standards and the annual Medical Corps (physician) Distribution Conference. Physician staffing is determined by patient care, graduate medical education, and military readiness requirements. There are 64 physician staff, 60 fellows in training, 49 residents in training, 60 enlisted, 190 civilians, and 154 affiliated staff in the DoM.

7. Standards or Guidelines for Practice.

The DoM follows the tenants of Army Regulations and JCAHO standards. The DoM has established treatment guidelines for peptic disease, angina, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, hyperlipidemia, gastroesophageal reflux disease, allergic rhinitis, and the use of non-steroidal anti-inflammatory drugs for use at WRAMC and affiliated primary care clines. Adherence to appropriate standards of care is evaluated within each Service under the auspices of its Performance Improvement Plan.

8. Assessing and Meeting Patient Care Needs.

Each individual Service in DoM has a Performance Improvement (PI) Plan which is reviewed and updated annually. Each plan uses adherence to threshold values for indicator activities and surveys for “sentinel events.” The Service PI coordinators meet monthly to review plans and data collection methods and report to the Quality Outcomes Committee. Patient needs are identified through periodic patient satisfaction surveys performed by the WRAMC Patient Liaison Office or by individual Services.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF PEDIATRICS
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services:

a. The Department of Pediatrics provides primary, secondary, and tertiary pediatric care to children from birth until age 23. Prenatal and neonatal services are available at our sister institution, The National Naval Medical Center (NNMC). The Pediatric Outpatient Department provides a full complement of general outpatient clinic services including acute care clinic, well-child care, health maintenance visits and continuity clinic. A comprehensive offering of pediatric subspecialty clinics are available to include: behavioral/developmental, cardiology, cleft palate, dermatology, endocrinology, exceptional family member, gastroenterology, genetics/ dysmorphology, dermatology/ oncology, infectious disease, HIV, Gulf-War Syndrome, metabolism, nephrology, nutrition, orthopedic, pulmonary, rheumatology and spina bifida clinic. Additional pediatric services offered outside of the Department of Pediatrics include the whole spectrum of surgical subspecialties (e.g. otolaryngology, phthalmology) and medical subspecialties (e.g. neurology, psychiatry, psychology radiology, physical and occupational therapy, speech, and allergy/immunology.) The adolescent clinic located at NNMC is a modern, comprehensive center that provides complete and comprehensive medical services for young adults. The outpatient department sees over 35,000 patients per year. These numbers do not include the patients seen at Fort Belvoir, Fort Meade, Andrews Air Force Base, Dover Air Force Base, Fort Bragg and other medical treatment facilities supported by the subspecialty services.

b. The inpatient ward admits over 2,000 children per year to the pediatric service and the pediatric surgical specialties. The pediatric intensive care unit cares for over 240 patients per year and over 1,000 children are seen annually for monitored, sedated procedures in a state-of-the-art sedation/recovery unit.

c. The Department of Pediatrics offers a pediatric Residency program that is fully consolidated with the National Naval Medical Center. Eleven interns, 10 PL2 and 10 PL3 training positions are offered per year. In addition, fellowship training in endocrinology, gastroenterology hematology/oncology, infectious disease and neonatology is available. Medical students from the Uniformed Services University of the Health Sciences and medical schools from around the country receive pediatric clinical training in the Department of Pediatrics.

2. Types and Ages of Patients Served.

The Department of Pediatrics provides direct patient care to the pediatric beneficiaries in the National Capital Area where over 100,000 children under age 17 are eligible for care. Because of the depth of its subspecialty expertise, the department serves as a worldwide referral center for the Department of Defense medical center, MEDDACs, and other health care treatment facilities, particularly those centers in Europe and along the East Coast of the United States.

3. Complexity of Patient Care Needs.

The full spectrum of primary, secondary and tertiary inpatient and outpatient pediatric care is offered to its beneficiaries. Specialized treatment to include pediatric critical care medicine is available as is nearly every pediatric subspecialty. Twenty-one military, four civilian and thirty-two house officers are required to meet health care needs.

4. Extent to Which Level of Care Meets Patient Needs.

Patient needs are identified by periodic family satisfaction surveys and through monthly performance improvement (PI) meetings. Non-availability statements are issued for services that are not offered at WRAMC or are not available in a timely fashion, with reimbursement via supplemental funds or third party payment. As part of a CHAMPUS recapture program for pediatric cardiac surgery, contractual agreements have been made with the Children's National Medical center to provide intensive care physicians for the Pediatric Intensive Care Unit at WRAMC.

5. Appropriateness/clinical necessity/timeliness of support reviews provided directly by the department or through referral.

a. **Support Services Utilized**: As an active, busy clinical service, The Department of Pediatrics relies on the support services of the entire Walter Reed Army Medical Center to include other clinical departments (i.e. nursing, surgery, allergy/immunology, radiology, nuclear medicine, pharmacy, psychiatry, social work, dermatology, neurology, physical medicine, audiology, etc.) as well as the full complement of administrative services from contracting, to logistics, to civilian personnel.

b. **Sources of Support Services**: As noted above, some personnel services are provided through contracts with Children's National Medical Center, Georgetown Hospital and a private contract nursing agency. Personnel on the faculty of the Uniformed Services University of the Health Sciences (USUHS) actively participate in patient care and mentorship for medical students, house officers and fellow. Clinical and Administrative Support Services are identified above. Equipment maintenance branch and contractually through outside civilian companies.

c. **Support Services Provided**: The Department of Pediatrics provides the entire spectrum of clinical care for pediatric patients and their families. Our Exceptional Family Member Program provides Army-wide administrative and health care support for Army dependent children with special needs. The pediatric staff provides direct care and consultive and referral services for all pediatric subspecialties listed in paragraph 1 for the medical community at WRAMC, the National Capital Area and the Department of Defense worldwide.

(1) The clinical pediatric staff provides teaching and mentoring for pediatric house officers, transitional interns, nurse practitioners, medical students, fellows and nurses. Numerous active, ongoing research projects and protocols are conducted by the staffs that also provide oversight and guidance for the research effort of house staff and fellows.

(2) All pediatric patients requiring conscious sedation are admitted to the pediatric sedation unit that has standardized the management of sedated children to insure optimal safety. The unit supports the recovery of patients undergoing both diagnostic and therapeutic procedures.

(3) Satellite clinics at Fort Meade, Andrews AFB, Fort Campbell, Fort Stewart, Fort Bragg and Eisenhower Medical Center are supported by the pediatric cardiology, gastroenterology, endocrinology, pulmonary, nephrology and development service.

d. **Appropriateness/clinical necessity/timeliness of support service provided:** Patients are seen directly by the department through referral. The support services provided by the Department of Pediatrics are integral to the clinical operations at Walter Reed. Pediatrics is pivotal, not only in providing state-of-the-art care, but also in supporting the training programs in surgery, neurology and obstetrics and gynecology. Generally, pediatric patients are seen in a timely fashion with significant waiting lists for children needing urgent or subspecialty care.

6. Availability of Necessary Staff.

Pediatric Services are provides 24 hours a day, 7 days a week throughout the year. These services are currently provided by 25 active duty military pediatricians, 4 civilian pediatricians, 31 house officers (who cover the pediatric services at WRAMC and NNMC), 2 administrators, 2 NCOICs, 5 secretaries, 3 outpatient nurses, and an impatient nursing staff (commissioned officers and civilians) and enlisted staff. Staff members are assigned to specific areas within the department but many are cross-trained so they can provide coverage to the other area when personnel shortages arise.

7. Recognized Standards or Guidelines for Practice.

The Department of Pediatrics follows AR 40-3, Federal Laws, JCAHO Standards and current professional guidelines and standards for pediatrics and the American Academy of Pediatrics.

8. Methods Used to Assess and Meet Patient Care Needs.

a. The Department of Pediatrics has a performance improvement program that reviews patient care parameters on a monthly basis. Pediatrics performance improvement is a planned, comprehensive and integrated program that utilizes “indicators” and related “thresholds” for evaluation. Each service reports to the committee twice a year.

b. Morbidity and mortality reviews and clinic pathologic conferences are organized on a regular basis to discuss high-risk patient care. All house officers are evaluated on a yearly basis.

c. Patient satisfaction surveys are conducted periodically in the outpatient clinic to assess the patients’ needs and to correct shortcomings.

PLAN FOR THE PROVISION OF PATIENT CARE
ALLERGY-IMMUNOLOGY DEPARTMENT
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Allergy-Immunology Department of Walter Reed Army Medical Center provides patient care services in five (5) major categories:

a. Diagnostic evaluations for both classic allergic (including rhinitis, asthmatic and other respiratory disorders) and immunologic disorders;

b. Therapeutic management of allergic, asthmatic and immunodeficiency disorders to include high complexity immune replacement and modulation therapy;

c. Preventative immune services to include tuberculosis screening (PPD), immunizations and travel medicine services;

d. Complex adverse drug/vaccine/anthrax reaction management and,

e. Patient and provider specific education and consultations.

A wide range of diagnostic tools are employed including prick and intradermal skin testing to evaluate IgE-mediated immune responses, delayed type hypersensitivity skin testing to evaluate cellular immune function and drug/vaccine challenges to assess hypersensitivity reactions. By prescribing allergy immunotherapy, providing expert consultation on anthrax vaccine related adverse events, delivering vaccinations for influenza and yellow fever prevention, or consulting about indications for intravenous immunoglobulin (IVIG), we are carrying out each of the last 4 types of services respectively.

The department has also integrated the new National Military Vaccine Healthcare Center (VHC), a collaborative initiative between the Department of Defense (DoD) and the Center for Disease Control and Preventive Medicine (CDC). This service has enhanced outreach to the North Atlantic Region and DoD as an expanded center of excellence for therapeutic management, education and data collection for improvement of immunization health care in general as well as for anthrax vaccine specifically. The department is also playing a key role in development of a network of national VHC's designed to meet the need of all uniformed services throughout the world. Finally, the departments hosts the United States Centralized Allergen Extract Lab that provides patient specific allergen extracts for immunotherapy in support of all uniformed services, the Veterans Administration and the Public Health Service.

2. Types and Ages of Patients Served.

The specialty provides services to patients of all ages, from neonate to the geriatric. Patient conditions range from healthy, such as those seeking routine immunizations, to those affected by excessive, malfunctioning, or deficient immune systems that result in numerous clinical problems involving multiple organs systems. At least 60% of our patient population is adult and approximately 40-50% are active duty personnel from all three services.

3. The Scope and Complexity of Patient Care Needs.

a. ***Descriptions of patient care processes and procedures.*** Clinic patients are referred by health care providers or via patient direct access requests for allergy-immunology services. The most common diagnoses include the following: allergic rhino-conjunctivitis-sinusitis, asthma, urticaria, anaphylaxis, insect allergy, primary and secondary immunodeficiency, chronic fatigue syndrome, adverse drug reactions, vaccine related hypersensitivity or complex adverse events management including anthrax, occupational lung disease, and a variety of diseases associated with immune dysregulation. Numerically speaking, preventive immunizations and disease screening skin testing are the greatest workload number for the clinic. Special procedures performed for the patients, depending on diagnostic consideration, include skin testing (e.g., aeroallergen, foods, medication, insect venoms, drugs, or vaccines), nasal smears for detection of nasal eosinophils, spirometry, and radiologic visualization of the sinuses (x-ray or CT), rhinoscopy, or specialized immunologic testing for definition of an immune disorder. Specific challenge procedures for food, drug or vaccine allergies require an emergency treatment area for possible anaphylaxis are also performed. Therapeutic measures typically implemented include antihistamines, inhaled steroids, bronchodilators, allergy or venom immunotherapy (both traditional and rush), antibiotics, intravenous immunoglobulin, oral immunosuppressive therapy, and immunizations.

b. ***Complexity: inpatient, outpatient, primary, tertiary***. More than 90% of patients seen are outpatients presenting to the clinic area; the remainder is hospitalized. Approximately 85% of patients live locally. An additional 10% are referred from within the North Atlantic Health Services Region and about 5% from outside the region. Inpatient consultations range from delayed-type hypersensitivity skin testing (anergy screening) and/or tuberculosis screening (PPD) to emergent drug allergy questions to complex allergy-immunology questions that may impact on overall patient management, including both primary and secondary immunodeficiency. Some consultations occur because of a grave need for diagnosis such as patients with unexplained recurrent infections or adults with chronic fatigue syndrome who have seen an average of more than 10 specialists. Others relate to the need for complex analysis of therapeutic options and a pressing need for better therapy such as a 20 year-old with sinusitis-nasal polyposis in relapse despite medication and 5 surgical procedures. This specialty service also serves as the primary resource for addressing the increased needs for assessing off-label applications of intravenous immunoglobulin therapy applications. Special procedures such as rush immunotherapy for venom hypersensitivity (high military readiness application) or procedures specific to our specialty (e.g. penicillin skin testing and drug desensitization) are the other indications for our services. Increasingly, the complexities of adverse reaction management associated with vaccines have resulted in referrals for diagnosis, management and exemption status recommendations. As an additional challenge, the staff is increasingly called upon to provide extended communication regarding the benefits versus risks for making informed decisions about vaccination strategies.

4. The Extent to Which the Level of Care or Service Provided Meets the Patients' Needs.

a. ***Mechanisms used to identify patient care needs***. Four (4) general types of mechanisms exist: (1) patient or patient surrogate-as-messenger of need (e.g. a parent, spouse, hospital staff member), (2) written, (3) telephonic, and (4) electronic communications via provider specific and/or group consultant e-mail support (ask allergy@…, ask anthrax@… and ask extract lab@amedd.army.mil). Patients or a surrogate hand-carry consultation-requests and come in person to our clinic. For established patients, prescription-refills and acute, condition-specific care are usually performed on a same-day basis. All patients undergo an assessment for pain and barriers to care such as language, vision, and religion. Patients seeking immunizations are also assessed using screening questionnaires that were designed to identify needs and potential contraindications impacting on care.

For those related to foreign-travel, staff consult the TRAVAX computer database (with weekly updates loaded at time of receipt of software). Consultation and prescription requests for allergy and venom immunotherapy arrive at the clinic and at the Extract Lab respectively by mail or Fax. Medical staff in particular, nurses or technicians at outlying allergy and immunization clinics, call designated staff members known as Consultants of the Day (COD) in order to receive answers to questions related to immunotherapy, immunizations or adverse vaccine reactions. Medical staff from other departments at Walter Reed and from other facilities as remote as the 121st Evacuation Hospital in Seoul, Korea transmit questions electronically via E-mail. The department hosts an official pollen & mold spore counting station with results posted by Email and broadcast on local network television. There is an increasing demand for e-mail consultative support services for a wide range of allergy-immunology specific issues, particularly in the areas of latex allergy, asthma management, and immunization health care issues.

b. ***Mechanisms for patient referral from another source of care.*** Patient referrals are routed through the regional TRICARE contractor appointing system, the hospital central appointing system and directly through clinic front desk personnel. If availability of outpatient appointment times exceed the standard of 30 days (0-1%) and no adjustments can be made, our quality improvement plan calls for us to advise patients of the expected wait time and to inform them of other realistic options at other military treatment facilities or within the TRICARE network of providers.

5. The Appropriateness, Clinical Necessity, and Timeliness of Support Services.

a. Examples of support services we use:

Support Services	Examples of Uses
Pulmonary Function Testing Laboratory	Lung function and provocation testing
Radiology Service	Sinus & chest CT scans
ENT and Speech Pathology	Dysphonia, Laryngeal dyskinesia
Clinical Investigation	Patient-care related protocols
Pharmacy	Mixing IVIG, drug desensitizations
Purchasing and Contracting	Extract Lab supply contract /staffing
Directorate of Information Management	Local Area Network-Extract Lab, Immunization Database management
Deployment Health Center	Complex patients with adverse events temporally linked to occupationally required immunizations
Specialty Consultations: Neurology, Gastroenterology, Psychiatry, Psychology, Sleep Disorder Center, Social Services, etc.	Complex patient management issues, medical boards, adverse vaccine and other drug reactions to include immunizations, medical exemption determinations

b. ***Compensation for external support****:* The Extract Lab recovers costs from the Navy, increasing numbers of Air Force Facilities, the Veterans Administration, and Public Health Service; a precedent for outlying facilities to reimburse for on-site mass influenza immunization now exists; third party collections from patients with insurance besides TRICARE or Medicare are limited but ongoing along with some third party collections for providing allergen and venom extracts.

c. ***Examples of Support services we provide:***

Support Services	Examples of Users
PPD / Anergy Testing	Infectious Disease, Inpatient wards
Immunotherapy	Beneficiaries & employees
Extracts for skin testing or immunotherapy	Clinics, hospitals, offices worldwide
Immunizations and support for medical exemption determinations	Deploying soldiers, Walter Reed beneficiaries, Region and DoD facilities requesting assistance. All ages for Travel. Occupational health support
Diagnosis, management, exemptions, and reporting support services for adverse events related to immunizations	AMEDD, Anthrax Vaccine Immunization Program (AVIP), Center for Disease Control & Preventive Medicine (CDC), DoD, Uniformed Services University of the Health Sciences
Training Of Immunization Specialists	Army, Navy, Air Force, VA Medical Treatment Facilities
Dissemination of pollen and mold counts	Local patients, local and nationwide allergists

d. ***Clinical necessity and timeliness of these support services:***

Support Services	Why Needed or By Whom	Timeliness
PPD / Anergy Testing	Infection Control Immune system work-ups	Placement: M, T, W & F Readings: M, W, Thu, Fri
Immunotherapy Extracts	Severe allergies Sting anaphylaxis	Prescription turn-around-time ~ 2 weeks
Immunizations	Military readiness; Travel; Medical Conditions	Afternoon: M, T, W & F Morning: Thurs
Training Immunization Specialists	Safe/Effective Immunotherapy & immunizations	8 course per year 12-15 students / course
Consultations to inpatient services and outlying clinics	Specialized knowledge Lack of an Allergist	Inpatients: urgent- same day; routine- <72 hrs Outpatients: urgent- same day to 72 hrs; routine <30 days Phone- Duty hours
Pollen and mold spore counts	Accurate diagnosis; Public interest, provider education	Published each weekday

6. Availability of necessary staff; description of the staffing plan for various activities; and the management of staffing variances.

Activities	Staff Totals	Staffing Plan	Flexibility from:
New Outpatient Evaluations	WRAMC fellows- 4; Other trainees- 1-3; Staff- 2-4; techs- 3-5; RN's- 1	Time divided: new & follow-up patients; and conferences	Doctors with no-shows; Walk-in doctor; inpatient doctor; Consultant Doctor (COD)
Inpatient Consultations	2-4 staff; 7-9 fellows	Rotating 1 fellow-1 staff teams	Staff second call (COD) Trade of days/ rotations
Immunizations / Allergy & Venom Immunotherapy	RN (1), techs (4), 1 NCO's (3)	Staggered schedules for 0700 opening and lunch coverage	Specialists Course Cross-training
Clinic precepting; Response to phone calls & e-mail	2-4 staff average availability on any one day	Teams of 2-3 Staff Doctors	Trading Times More duty Solo Consultant
Immunization healthcare quality improvement, VAERS support, Clinical Research	Staff physicians- 1-5; nurse practitioners- 3; research protocol support (variable)	Primary consults to VHC staff; nurse practitioner supervision by VHC physician or clinic staff	overflow to clinic consultation or inpatient physicians
Questions from other doctors and patients via E-mail	2-4 staff doctors available daily;	Ask allergy or Ask anthrax or Ask extract lab @amedd.army.mil Email outreach groups	Staff /fellow inpatient team; questions open to response from all providers

7. Recognized standards or guidelines for practice utilized by Allergy-Immunology Department including Vaccine Healthcare Center (VHC)

a. **Diagnosis and Management of Rhinitis**: Complete guidelines of the Joint Task Force on Practice Parameters in Allergy, Asthma and Immunology; *Mark S Dykewicz: Stanley Fineman*; **Annals of Allergy, Asthma, and Immunology**, Palatine; Nov 1998; Vol. 81, Iss. 5; pg. 478, 41 pgs

b. Executive Summary of Joint Task Force Practice Parameters on Diagnosis and Management of Rhinitis.; *Dykewicz MS*; **Annals of Allergy, Asthma and Immunology [NLM - MEDLINE]**; Nov 1998; Vol. 81, Iss. 5; pg. 463

c. Joint Task Force Algorithm and Annotations for Diagnosis and Management of Rhinitis.; *Dykewicz MS*; **Annals of Allergy, Asthma and Immunology [NLM - MEDLINE]**; Nov 1998; Vol. 81, Iss. 5; pg. 469

d. Patterson R, Hogan MB, Grammer LC. Rhinitis. Ann Allergy 1994;72:293-302.

e. Resources on-line for Asthma Guidelines:
(1) www.aaaai.org/aadmc/currentliterature/asthmaguidelines.html (AAAAI).
(2) www.nhlbi.nih.gov/nhlbi/nhlbi.htm (NAEPP/NHLBI materials).
(3) www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm (1997 Expert Panel Report).
(4) www.nhlbi.nih.gov/guidelines/asthma/execsumm.pdf (2002 Expert Panel Update).

f. International Consensus Report on Diagnosis and Management of Asthma, National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, Maryland 20892. Publications No. 92-3091, June, 1992; U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

g. Practice parameters on the diagnosis and treatment of asthma and practice parameter on number of skin tests, Joint Task Force on Practice Parameters for Allergy & Immunology, a joint venture of the American Academy of Allergy and Immunology [now the American Academy of Allergy, Asthma, and Immunology] and the American College of Allergy and Immunology [now the American College of Allergy Asthma and Immunology], with input from the Joint Council, with substantial contributions from each organizations, Supplement to the Journal of Allergy and Clinical Immunology vol 96, No. 5, Part 2, November 1995.

h. Report of the Working Group on Asthma and Pregnancy, Management of Asthma during Pregnancy, National Institutes of Health, National Heart, Lung, and Blood Institute, Public Health Service, U.S. Department of Health and Human Services, NIH Publication No. 93-3297, September 1993.

i. Core Curriculum on Tuberculosis, All the clinician should know, fourth edition, 2001, U.S. Department of Health and Human Services, Public Health Services Centers for Disease Control AND Prevention, National Center for Prevention Services, Division of Tuberculosis Elimination, Atlanta, GA.

j. The Peak Flow Meter Book, a Guide for People with Asthma, Nancy Sander, Guillermo Mendoza, Martha White, Allergy and Asthma Network, Mothers of Asthmatics, Inc. 3554 Chain Bridge Road, Suite 200, Fairfax, VA 22030-20709.

k. How to Help Your Patients Stop Smoking, a National Cancer Institute Manual for Physicians, U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, Thomas J. Glynn, Ph.D, Marc W. Manley, MD, MPH, Smoking and Tobacco Control Program, Division of Cancer Prevention and Control, National Cancer Institute, NIH Publication No. 92-3064, revised November 1991.

l. A series of practice parameters are listed at the following website: http://www.jcaai.org/Param/ Practice Parameters for the Diagnosis and Treatment of Asthma. J Allergy Clin Immunol (Nov) 1995;96:S707-S870.<O:P</O:P

(1) Practice Parameters for Allergy Diagnostic Testing. Ann Allergy Asthma Immunol (Dec) 1995;75:S543-S625.

(2) Practice Parameters for the Diagnosis and Management of Immunodeficiency. Ann Allergy Asthma Immunol (March) 1996;76:282-294.

(3) Practice Parameters for Allergen Immunotherapy. J Allergy Clin Immunol (Dec) 1996;98:1001-1011.

(4) Disease Management of Atopic Dermatitis: A Practice Parameter. Ann Allergy Asthma Immunol (Sept) 1997;79:197-211.

(5)The Diagnosis and Management of Anaphylaxis. J Allergy Clin Immunol (June) 1998;1001:S465-S528.

(6) Algorithm for the Diagnosis and Management of Asthma: A Practice Parameter Update. Ann Allergy Asthma Immunol (Oct) 1998;81:415-420.

(7) Diagnosis and Management of Rhinitis: Parameter Documents of the Joint Task Force on Practice Parameters in Allergy, Asthma and Immunology. Ann Allergy Asthma Immunol (Nov) 1998;81:S463-S518.

(8) Parameters for the Diagnosis and Management of Sinusitis. J Allergy Clin Immunol (Dec) 1998;102:S107-S144.

(9) Stinging Insect Hypersensitivity: A Practice Parameter. J Allergy Clin Immunol (May) 1999;103:963-980.

(10) Disease Management of Drug Hypersensitivity: A Practice Parameter. Ann Allergy Asthma Immunol (Dec) 1999;83:665-700.

m. Adverse Events to Vaccines and Information Regarding Anthrax Vaccine Immunization Program (AVIP):

(1) **Anthrax Vaccine** -- 13 safety studies, involving > 366,000 vaccine recipients, plus concurrence of six independent civilian reviews, with ongoing surveillance. Details available @ www.anthrax.osd.mil. Toll-free Question & Answer Service: 877-GET-VACC

(2) Subscribe to weekly mailing www.anthrax.osd.mil/temp/listsubscribe.asp

(3) Clinical guidelines for adverse events temporally related to non-live vaccines and vaccine adverse events reporting: Details available @ www.anthrax.osd.mil

(4) www.cdc.gov

Extensive resources & linkages including ALL currently updated Vaccine Information Sheets (VIS) for patient educational requirement Morbidity Mortality Weekly Reports FULL TEXT available at this website with search function. Contains ALL ACIP recommendations as well as travel specific information; MMWR December 2000: ACIP Statement on Anthrax Vaccine

(5) www.anthrax.osd.mil (AVIP home page)

DocuCenter has extensive educational material and references regarding anthrax, anthrax vaccine and other BW agents as well as useful linkages to other DoD sites of interest; Information regarding classification of anthrax & other vaccine related medical exemptions

(6) http://chppm-www.apgea.army.mil: provides vaccine information sheets on travel vaccines not found at CDC website as well as other information about drug prophylaxis for service members & travelers.

n. **Physician Reference Materials: Position Statements Index**

(1) Environmental allergen avoidance in allergic asthma JACI, Vol. 103, February 1999, pp. 203-5

(2) Idiopathic environmental intolerances JACI, Vol. 103, January 1999, pp. 36-40

(3) Anaphylaxis in schools and other child-care settings JACI, Vol. 102, No. 2; August 1998, pp.173-6

(4) Position Statement on the Discontinuation of Hymenoptera Venom Immunotherapy JACI, Vol, 101, No. 5; May 1998, pp. 573-5

(5) The Future of the Subspecialty of Allergy and Immunology JACI; Vol. 100, No. 4; October 1997, pp. 441-443

(6) Role of the Allergist/Immunologist as a subspecialist JACI; Vol. 100, No. 3; October 1997; pp. 288-289

(7) Training Program Directors Committee Position Statement on Health Care Reform JACI; Vol. 98, No. 4; October 1996; pp. 719-720

(8) Safety and Appropriate Use of Salmeterol in the Treatment of Asthma JACI; Vol. 98, No.3; September 1996; pp. 475-480

(9) Measurement of Specific and Nonspecific IgG4Levels as Diagnostic and Prognostic Tests for Clinical Allergy; JACI; Vol. 95, No. 3; March 1995; pp. 652-654

(10) Health Care Reform; AAAAI Board of Directors; JACI; Vol .95, No. 4; April 1995; pp.797-800

(11) The Use of Epinephrine in the Treatment of Anaphylaxis JACI; Vol. 94, No. 4; October 1994; pp. 666-668

(12) Guidelines to Minimize the Risk from Systemic Reactions Caused by Immunotherapy with Allergenic Extracts; JACI; Vol. 93, April 1994; pp. 811-812

(13) Allergen Skin Testing; JACI; Vol. 92, No. 5; November 1993; pp. 636-637

(14) Inhaled Corticosteroids and Severe Viral Infections; JACI; Vol. 91, No. 8; August 1993; pp. 223-228

(15) Inhaled Beta-Adrenergic Agonists in Asthma; JACI; Vol. 91, No. 6; June 1993; pp. 1234-1237

(16) The use of In Vitro Tests for IgE Antibody in the Specific Diagnosis of IgE Mediated Disorders and the Formulation of Allergen Immunotherapy; JACI; Vol. 90, No. 2; August 1992; pp. 263-267

(17) The Use of Anhydrous Theophylline in the Management of Asthma; October 1990

(18) The Waiting Period After Allergen Skin Testing and Immunotherapy* * Addendum to the AAAAI Position Statement on Personnel and Equipment to Treat Systemic Reactions Caused by Allergen Immunotherapy ; JACI; Vol. 85, No. 2; February 1990; p. 526

(19) The Use of Inhaled Medications in School by Students with Asthma; JACI; Vol. 84, No. 3; September 1989; p. 400

(20) Beta-Adrenergic Blockers, Immunotherapy and Skin Testing; JACI; Vol. 84, No. 1; July 1989; pp. 129-130

(21) The Use of Antihistamines in Patients with Asthma; JACI; Vol. 82, No. 3; September 1988; pp. 481-482

(22) Measurement of Circulating IgG and IgE Food-Immune Complexes; JACI; Vol. 81, No. 4; April 1988; pp. 758-760

(23) Position Statement
(a) on Clinical Ecology
(b) on Candidiasis Hypersensitivity Syndrome
(c) on Carotid Body Resection
(d) on Unproven Procedures for Diagnosis & Treatment of Allergic & Immunologic Diseases; JACI; Vol. 78, No. 2; August 1986; pp. 269-277

(23) Remote Practice of Allergy; AAAAI Executive Committee; JACI; Vol. 77, No. 5; May 1986, pp. 651-652

(24) Personnel & Equipment to Treat Systemic Reactions; JACI; Vol. 77, No. 2; February 1986, p. 271

(25) Adverse Effects & Complications of Treatment with b-Adrenergic Agonist Drugs; JACI; Vol. 75, No. 4; April 1985; pp. 443-449

(26) Skin Testing & Radioallergosorbent Test (RAST) for Diagnosis of Specific Allergens Responsible for IgE Mediated Diseases; JACI; Vol. 72, No. 5, Part I; November 1983, pp. 515-517

(27) Role of Allergists in Hospitals; AAAAI Executive Committee, September 1982.
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(b) Urine Autoinjection (Autogenous Urine Immunization)
(c) Skin Titration (Rinkel Method)
(d) Provocation Testing (Sublingual);JACI; Vol. 67, No. 5; May 1981; pp. 333-338

(29) Statement on Resuscitative Equipment; JACI; Vol 67, No. 1; January 1981, p. 1

(30) Position Statement
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(b) on Use of Radioallergosorbent & IgE Tests in Practice
(c) on Participation in Meetings Advocating Unproven Techniques; JACI; Vol. 66, No. 6; December 1980; p. 431

(31) RAST Marketing; Joint Council of Allergy & Immunology; July 1979

(32) Statement by the Executive Committee
(a) IgE Tests; JACI
(b) Methods of Practice Regarding Lab Procedures; JACI; Vol. 62, No. 2; 1978; p. 71

(33)From the Executive Committee
(a) Conference Participation (adopted 3/25/77)
(b) Voluntary Health Organizations (adopted 9/10/76)
(c) Tartrazine (adopted 3/27/77)
(d) Epinephrine Injections (adopted 3/30/77)

(34) Some Untested Diagnostic & Therapeutic Procedures in Clinical Allergy; JACI; Vol. 56, No. 3; September 1975; pp. 168-169

(35) Statement on the Questions of Allergy to Fluoride as Used in the Fluoridation of Community Water Supplies; JACI; Vol. 47, No. 6; June 1971; p. 347

8. Methods that are Used to Assess and Meet Patient Care Needs.

a. Department Quality Improvement/Performance Improvement Plan: The plan calls for the following indicators which directly or indirectly reflect patient care needs:

Indicator or Source of Data	**Components**
Adverse reactions: adverse reaction work sheets	Skin testing, immunizations, allergy immunotherapy, IVIG
Clinic customer satisfaction: hospital and clinic surveys	Quality of care, facility, access to care, personnel interactions
Asthma management outcomes: clinical research, drug usage audit, chart review	Number of hospitalizations & emergency room visits, quality of life and lung function
Allergen Extract Lab— quality control and improvement program	Prescription compounding errors, sterility testing, patient-incidents involving, wait times
Vaccine related Adverse Events Reporting, VHC database	VAERS filed on patients being evaluated to include follow-up VAERS on complex patients
Appointment Access Standards	% New open; # New open; % New reserved for prime; # receiving care in civilian network
Risk Management 2.I. Report (1811)	Fall, medical errors, practice procedure variance

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF CLINICAL INVESTIGATION
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Clinical Investigation (DCI) is a research support facility of Walter Reed Army Medical Center. Specifically, DCI performs oversight of the clinical investigation and research program involving human, animal, and laboratory related studies; and provides support to the clinical investigators in the areas of research review; biometrics; automation support; research administration, personnel, and funding; research laboratory support; and associated research process, application, publication, and education. Thus, the department's main function is to provide support for the physicians, fellows, and medical students interested in pursuing research at WRAMC. In this capacity, the laboratories of the Department of Clinical Investigation do not engage in direct patient care and do not use our results as tools for diagnosis purpose.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF MINISTRY AND PASTORAL CARE
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department offers pastoral care and other spiritual services to all patients, family members, and staff at WRAMC and its tenant units.

2. Types and Ages of Patients Served.

All patients, family members, staff, and their family members, regardless of age (neonate to geriatric) are potential recipients of the services of the Department of Ministry and Pastoral Care.

3. Scope and Complexity of Patient Care Needs.

a. Patient Care Processes/Procedures: During the regular work week, inpatients are visited by a chaplain within 48 hours of admission. A chaplain visits pre-operative patients before surgery, using the OR schedule which is published daily. Patient requests to see a chaplain are answered within 24 hours; triage is used to determine order of response. Chaplains respond immediately to all death situations (when notified), to ER 'calls for a chaplain, to Redbird calls and other emergency situations as needed. During weekday afternoons, our year-long Clinical Pastoral Education Residents make regular, systematic visits to patients on the wards and in outpatient clinics to which they are assigned. Particularly in inpatient settings, our chaplains make every reasonable effort to document their pastoral care interventions, when appropriate, in patients' medical records. On-call, in house Protestant and Roman Catholic Duty Chaplains are available 24 hours/day; 365 days/year.

b. Complexity: The complexity of patient needs ranges from the most minimal ("Could you please bring me a Bible?"), to the most difficult and complex ("The doctors say we need to make a decision about whether to pursue any further treatment for Dad; the family would like to talk with a chaplain.) We are constantly being made aware of the range of patient needs in the area of spiritual life and are endeavoring to be sensitive and responsive in meeting those needs. We are developing and using surveys with inpatients, including same day surgery patients, to help us better meet patient needs. The Department no longer distinguishes between outpatient and inpatient chaplains. Chaplains are assigned to the hospital's departments and services with the intention of providing a continuum of pastoral care to both outpatients and inpatients. Chaplains provide routine pastoral care to acute, tertiary inpatients, and respond to patient requests/staff referrals for chaplain services, whether outpatient or inpatient, that arise within their assigned department of service.

4. Extent to Which Level of Care Meets the Patient's Need.

a. Mechanisms Used to Identify Patient Care Needs: We employ several methods to identify patient care needs: the patient's self-reported religious affiliation on admission or registration within our system; information recorded in the patient record; the chaplain's determination of a patient's religious support needs during an initial visit; requests from the patient or staff/family member requests that concern the patient; and surveys that identify the patient's spiritual/pastoral care needs.

b. Mechanism for Referral of Unmet Religious Needs: We have a range of referral resources which we are able to use when we cannot meet a patient's religious needs with in-house chaplain assets. We have a Rabbi under contract who provides on-call pastoral care to Jewish patients. We have contract Catholic priests who provide pastoral care to Catholic patients. Beyond that, and beyond the variety of denominational affiliations/expertise represented on our staff, we have a list of local pastors and congregations who have offered their support when we call on them.

5. Appropriateness, Clinical Necessity, Timeliness of Support Services Provided Directly by the Organization or Through Referral Contracts.

Please see 3 and 4 above. The Department utilizes numerous administrative support services throughout the Medical Center. It utilizes Walter Reed support services, and some contract service~. The Department provides pastoral support throughout the Medical Center which is particularly sensitive to, and responsive to, clinical necessities and timeliness.

6. Availability of Necessary Staff.

a. Our focus is to provide quality pastoral care and other spiritual services on an ongoing, daily basis, with as much consistency in coverage as we can possibly manage in order to maximize benefits to our pastoral care recipients.

b. To do this, the Department has on-call, in-house Protestant and Catholic Duty Chaplains available 24 hours/day, 365 days/year. During normal duty hours, chaplain clinicians and the Clinical Pastoral Education residents they mentor provide a continuum of pastoral care to both outpatients and inpatients (along with family members and staff) within their assigned hospital departments and services. A Chaplain-Clinical Ethicist with advanced training in clinical ethics provides health care ethics consultation education and training to patients, their families and staff. A Wellness Chaplain provides specialized pastoral care in preventive health settings. The Medical Center Brigade Chaplain's duties include providing pastoral care to hospital staff and their families. A Rabbi under contract provides on-call pastoral care to Jewish patients. Contract Catholic priests provide pastoral care to Catholic patients.

7. Recognized Standards/Guidelines for Practice.

The Department follows AR 40-2, AR 165-1, JCAHO standards, and current professional guidelines and standards for the practice of effective and proficient pastoral care. Chaplains assigned primary patient care responsibilities in any Army Medical Center must have completed a one year residency in Clinical Pastoral Education.

8. Methods to Assess/Meet Patient Care Needs.

Our primary and ongoing method is the constant feedback we receive from the patients themselves, staff members and family members. We are periodically included in patient satisfaction surveys, and we respond to identified areas in those reports. Our informal quality improvement plan has helped us recognize and respond to the need to provide pastoral care to outpatients, to provide chaplain coverage in the health promotion arena, and to provide the services of a chaplain-clinical ethicist to enhance patient care.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF NEUROLOGY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

a. Neurology provides both inpatient and outpatient services including diagnosis, treatment, and medical disposition of neonate through geriatric beneficiaries referred with neurologic complaints.

b. Constituent aspects of this service include operation of both Adult and Child Neurology clinics, as well as an Adult Neurology Inpatient Ward. Pediatric Neurology inpatients are cared for on the Department of pediatrics Inpatient Ward with the Child Neurology Service staff serving as their attending physicians. Other components include Neuro-Ophthalmology, Behavioral Neurology, Epilepsy and Movement Disorder Clinics providing both diagnostic and consultative services and a Clinical Neuro-physiology laboratory providing a wide variety of diagnostic studies.

2. Types and Ages of Patients Served.

All patients in the DEERS system are eligible for care. The department provides comprehensive neurologic care to all ages.

3. Scope and Complexity of Care.

Services are available to all military beneficiaries within the National Capitol Area and NARMC areas. Also, as the Army's principal tertiary neurologic referral center, this department is available for consultation or patient referral to all military beneficiaries worldwide. The department is capable of providing the most sophisticated level of subspecialty care in most areas.

4. Extent that Care Provided Meets the Patient's Needs.

a. The department provides comprehensive neurologic care. Rarely, patients require referral elsewhere for further subspecialty care. Occasional patients are shared with the NIH Clinical Center, NNMC and other referral centers.

b. The mechanism used to assess patient care needs generally begins with referral to one of the Neurology clinics (Adult, Child) or one of the subspecialty clinics (Neuro-ophthalmology, Epilepsy, Movement-Disorder, Behavioral Neurology, etc.), or the Inpatient Consultation Service. If judged appropriate, the patient. may be admitted to the hospital for more extensive evaluation. Certain categories of patients may be admitted directly to the Inpatient services. These include emergencies and hospitalized patients transported by the military medical air-evacuation system from other medical treatment facilities around the globe.

5. **Appropriateness, Clinical Necessity and Timeliness of Support Services.**

a. This Department provides neurologic consultative services to all inpatients (both adult and pediatric) at WRAMC. Patients may be transferred by neurologists or other physicians at other hospitals or medical centers for evaluation and care.

b. The Neurophysiology Laboratory provides diagnostic studies including: EEG, sleep studies, telemetry studies, intra-operative and prolonged electrocorticography, visual, auditory, and sensory evoked potentials (both in the laboratory and intra- operative), motor evoked potentials, cEMG, and NCV studies. Definitive interpretation of these studies is provided by staff with subspecialty certification in Neurophysiology.

c. The Neuro-Ophthalmology Service provides consultative service on all aspects of diagnosis and therapy related to neurologic disorders of the visual system.

d. The other Departments and Services upon which the Neurology Department most relies include:

(1) Neuro-Radiology - for all aspects of imaging of the nervous system and its supporting structures (MRI, MRA, CT, plain film, arteriogram, myelogram, etc.).

(2) Neurosurgery - for the surgical aspects of neurologic disease, including diagnostic biopsy and treatment.

(3) Psychiatry - providing psychiatric evaluation of disorders of the brain.

(4) Physical Medical & Rehabilitation Service - providing their special expertise in the therapy of patients with neurologic disease.

(5) Neuro- Pathology - both of the WRAMC Anatomic Pathology Service and the Department of Neuropathology, Armed Forces Institute of Pathology - for interpretation of brain, nerve, muscle, and other biopsy specimens.

(6) WRAMC Clinical Laboratory Service - for the performance and interpretation of chemical and other studies performed on specimens of blood, urine, cerebrospinal fluid, etc.

(7) Neuro-Psychology - for neuropsychologic testing helpful in evaluating cognitive function of our patients.

(8) Audiology and Speech Pathology - for performance and interpretation of hearing tests, ENG, swallowing studies, speech assessments, etc.

(9) Social Work - for assistance in arranging after hospital care for our patients on the Neurology Ward.

(10) Every other clinical Department at WRAMC - for their assistance when our patients have problems germane to their field.

(11) WRAMC Department of Nursing - for the care of our patients on the inpatient Service.

(12) General support services including Dietary, Engineering, Housekeeping, etc.

6. Standards & Guidelines of Practice.

The Department functions within the hospital framework and thereby complies with the Joint Commission on the Accreditation of Healthcare Organizations. Each individual practitioner maintains a current state license. First year neurology residents (PGY-II) must obtain such a license before beginning PGY-III. All staff in the Department maintains current BCLS certification.

7. Methods to Assess Success in Meeting Patient Care Needs.

a. The Department maintains an active Performance Improvement program, directed by a neurology staff physician.

b. The Department participates in hospital sponsored patient satisfaction surveys.

8. Staffing.

Patients seen at Walter Reed are seen by physicians who may be primarily assigned to Walter Reed, Bethesda, NIH, Malcolm Grow and credentialed to practice medicine at Walter Reed. The number of staff varies with time, but includes about 25 Neurologists and 10-15 residents/fellows in Neurology or Neurology subspecialties.

PLAN FOR PROVISION OF CARE
WRAMC NURSING
WALTER REED ARMY MEDICAL CENTER

1. Purpose. To define Nursing's role in the plan for the provision of patient care and describe the scope of service for WRAMC Nursing.

2. References.

a. American Nurses Association. Standards of Clinical Nursing Practice, 2nd Edition, 1998.

b. WRAMC Reg 40-92, Patient Care Committees, Boards and Councils, Aug 2002.

c. Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations, current edition

d. AR 570-4, Manpower Management, 15 May 2000.

e. FM 8-501, The Workload Management System for Nursing, Nov 1990.

f. WRAMC Regulations

g. WRAMC Nursing Policies

h. Smith, Sandra F. & Duell, Donna J. Clinical Nursing Skills, 4th ed. Appleton & Lange. 1996.

3. Responsibilities. The Deputy Commander for Nursing (DCN):

a. Provides direction and leadership for all nursing activities within the Medical Center. Advises the Commander and other leadership staff on all matters pertaining to nursing services and personnel across all department/divisions.

b. Participates in the organizational leadership to include membership on the hospital's Executive Committee of the Medical and Administrative Staff in addition to the Governing Body. Analyzes data for corporate decision making and participates in discussions and decisions pertaining to mission, budget, resource management, access to care, performance improvement, and patient safety initiatives to support the delivery of quality health care.

c. Ensures standards of nursing practice and patient care standards are implemented in all areas providing nursing care.

d. Ensures appropriate number and skill mix of nursing staff are available and qualified to provide patient care.

e. Ensures current research findings are integrated into policies and procedures guiding the delivery of nursing care as well as standards of patient care and nursing practice.

4. Scope of Services.

a. Patient care is the systematic provision of interdisciplinary healthcare interventions designed to meet patients' physiological, psychological, and psychosocial needs with the goal of maintaining the highest level of health possible.

b. Nurses are responsible and accountable for all activities embodied in the practice of nursing, based on the nursing process. Nursing includes assessment of patient needs in terms of the client's response to actual or potential health problems, goal directed planning of care related to the identified needs, implementation or supervision of care, and evaluation of the effects of care in relation to expected outcomes.

c. Nursing care is provided under the auspices of a professional nurse in all inpatient as well as specified outpatient clinics and other settings to include perioperative services, community health services, and emergency services. Care is provided to a diverse patient population and encompasses the continuum of services from health promotion and wellness to the acute and highly complex disease/problem categories. Inpatient and emergency nursing services are available twenty-four hours per day.

d. Registered Nurses (RN) provide nursing and supportive care functions. Licensed Vocational/Practical Nurses, operating room, telemetry, and psychiatric technicians, as well as military medics/civilian unlicensed assistive personnel assist in the provision of patient care and interventions under the direction of a professional RN. Nursing and supportive care is provided by military, civilian and contract personnel.

5. Patients Served.

Age specific patient care is provided to patients ranging in ages from neonate to geriatric. The descriptions of specific patient populations by inpatient, outpatient, and community services are detailed in individual unit scopes of service.

6. Complexity of Patient Care Needs.

The complexity of patient care needs ranges from wellness and health promotion education through intensive inpatient and end of life care. Patient needs are addressed at the individual, family, and population levels. Specific descriptions are detailed in the individual unit scopes of service.

7. Methods used to Assess and Meet Patient Care Needs.

Nursing uses a variety of mechanisms to assess requirements and plan patient care services. Patient population demographics, beneficiary needs, and hospital mission determine services provided in accordance with professional nursing organizations' standards of care. Services are further refined based on patient satisfaction, outcomes and performance improvement/ risk management data. The data are used to develop programs and services to meet patient needs, as well as evaluate effectiveness.

8. Staffing.

a. Each unit's overall minimal essential staffing requirements are defined by the Automated Staffing Assessment Model (ASAM), based on medical planning factors and historical workload. Determination of manpower requirements is a continuous process in which requirements are established, increased, decreased, and eliminated in response to changes in a unit's workload, missions, programs, procedures, technology, and leadership philosophy. Daily measurement and determination of workload is accomplished through the Workload Management System for Nursing (WMSN) on inpatient areas.

b. Workload Management System for Nursing is a management tool used to assess nursing personnel staffing based on patients' nursing care needs. Nurses classify patients according to an assessment of their nursing care needs for the next 24 hour period and determine the total number of nursing care hours (NCH) a unit's patients will require. This system provides solid factors to begin planning for patient care. The WMSN cannot stand as a single method for determining staffing requirements but can provide a good starting point for assessing the staffing needs of the unit when used in conjunction with other staff planning variables.

c. The Head Nurse and NCOIC formulate a unit nursing core staffing plan, defining the number and mix of nursing personnel required in accordance with professional judgment and current patient care needs. Staffing plans take into consideration the American Nurses Association “Principles for Nursing Staffing” and are contingent upon patient care, unit, staff and organization variables. Patient care variables are reflected in the WMSN, and include number of patients, level of acuity, and additional factors that may impact patient needs. Unit variables include characteristics of the unit’s care intensity, configuration and delivery support functions. Staff related variables reflect the specific needs of patient populations and determine the appropriate clinical competencies required of the nursing staff. Organization related variables include areas such as support services (clerical, transport, housekeeping, laboratory), and access to timely, relevant and accurate information.

d. Staffing is also adjusted based on patient need, staff expertise and experience. When additional staff are required to respond to increased patient care demands, augmentation is accomplished by detailing individuals from one area to another, supplementing core staff with contract employees or adjusting staffing schedules by initiating the “on call” roster or soliciting volunteers from the permanent staff to work overtime. Each nursing unit will develop a baseline core staffing plan matrix template based on the above factors.

e. Nursing care is provided to patients in the areas listed below. See Appendix B for individual unit Scopes of Services, with the exception of Ambulatory Nursing. Scopes of Services for Ambulatory Nursing areas are located in the respective Departmental/Service Plan for Provision of Patient Care.

(1) Critical Care Nursing Section
- 40 Coronary Care Unit
- 41 Coronary Care Stepdown
- 45A Surgical Intensive Care Unit
- 45B Medical Intensive Care Unit/Pediatric Intensive Care Unit
- 45C Intermediate Care Unit
- 46 Cardiothoracic
- 48D Dialysis
- Post Anesthesia Care Unit

(2) Surgical Neuroscience Services Section
- 57 Orthopedic Surgery
- 58 Neurosurgery
- 65 Gyn/Plastic Surgery
- 66/67 Preadmission Unit/Short Stay Unit
- 68 General/Vascular Surgery

(3) Medical /Psychiatric Nursing Section
- 53 Partial Hospitalization Program
- 54 Psychiatry
- 71 Medical-Oncology
- 72 Eisenhower Executive Suite
- 75 General Medicine

(4) Pediatric Nursing Section
- 51 Pediatric Ward
- 52 Pediatric Sedation
- Pediatric Clinic
- Pediatric Hem/Onc Clinic

(5) Perioperative Nursing Section
Operating Room
Central Material Service

(6) Ambulatory Nursing Section
Allergy Clinic
Cardiac Catheterization Laboratory
Cardiology Clinic
Comprehensive Breast Center
Emergency Room
Endocrinology Clinic
ENT Clinic
Gastroenterology Clinic
General Internal Medicine Clinic
General Surgery Clinic
Gynecology Clinic
Hematology/Oncology Clinic
Infectious Disease Clinic
Nephrology Clinic
Neurology Clinic
Oral Surgery Clinic
Orthopedic Clinic
Pain Clinic
Pulmonary Clinic
Radiology
Rheumatology Clinic
Urology Clinic
Vascular Surgery Clinic
Pentagon Health Clinic
Ft. McNair Health Clinic

9. Evaluation.

a. The Plan for Provision of Nursing Care will be reviewed annually in conjunction with strategic planning to ensure integration with the WRAMC Plan for the Provision of Patient Care.

b. Staffing effectiveness is evaluated by analysis of the relationship between human resource data (Nursing Care Hours per Patient Day and Skill Mix) and clinical outcome indicators (patient falls and medication errors). Staffing effectiveness analyses will be reported at the unit, section, department and organizational levels. Nurse staffing and clinical indicator data are reported to the Nursing Leadership Committee, and the Executive Committee of the Medical and Administrative Staff.

PLAN FOR THE PROVISION OF PATIENT CARE
NUTRITION CARE DIRECTORATE
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Nutrition Care Directorate (NCD) provides comprehensive nutrition services for inpatients and outpatients at WRAMC. These services include medical nutrition therapy, food production and service, education and research.

2. Types and Ages of Patients Served.

Inpatient services include care for patients on gynecology, pediatrics, psychiatry, and surgical and medical specialties. Surgical specialties include cardiothoracic surgery, general surgery, neurosurgery, orthopedic surgery, oral and maxillofacial surgery, organ transplant, otolaryngology, urology, and vascular surgery. Medical specialties include cardiology, endocrinology, gastroenterology, general medicine, hematology-oncology, infectious disease, nephrology, pulmonary and critical care medicine, and rheumatology. Services are provided for all ages throughout the life span: neonate, infant, childhood, adolescence, adulthood, and the elderly.

3. Scope and Complexity of Patient Care Needs:

a. **Patient care processes and procedures performed**: Medical nutrition therapy involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. This assessment consists of review and analysis of medical and diet histories, laboratory values, and anthropometric measurements. Based on the assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury are implemented and include: (1) diet modification and counseling leading to the development of a personal diet plan to achieve nutritional goals and desired health outcomes, and/or; (2) specialized nutrition therapies including intravenous (parenteral) or enteral nutrition.

b. **Complexity**: Since WRAMC is a regional, referral medical center, many patients have multiple medical problems, which often increase the complexity of the patient's nutritional needs. The level of inpatient complexity ranges from a patient with no nutritional problems receiving a regular diet by mouth to a patient with complex nutritional needs receiving parenteral nutrition. A Nutrition Support Team provides consultation services for patients requiring parenteral nutrition and for other patients with unique or complex nutritional needs. Inpatient dietitians support specialty clinics and counsel outpatients in those clinics.

4. Extent to Which Level of Care Meets Patient's Needs

a. Mechanisms used to identify patient care needs: The nursing comprehensive screening completed within the first 24 hours of admission functions as a preliminary screen for nutrition risk for inpatients. The diet technician then identifies and prioritizes patients needing nutrition intervention into one of three levels of care: (1) Level I - at low risk for clinically significant malnutrition; (2) Level II - mild to moderate risk for clinically significant malnutrition, and; (3) Level III - moderate to high risk for clinically significant malnutrition. These levels of care define the minimally expected services, follow-up time frames, and responsible provider. The "How's Your Health" survey and/or the nutrition questions on the health screening questionnaire administered at the primary care clinic identifies outpatients in need of nutrition services. Based on the client's answers to the survey, a referral to the Wellness Services for nutrition counseling may be initiated by the physician.

b. If unable to meet patient needs, mechanisms for patient referral to another source of care: Inpatients who are discharged with on-going nutrition care needs may be referred to the Wellness Services or to registered dietitians in their geographic area. In conjunction with Social Work, patients are also advised of community resources and food-assistance programs, as needed.

5. Appropriateness, Clinical Necessity, and Timeliness of Support Services Provided Directly by NCD or Through Referral.

a. Support services used: Numerous administrative services throughout the medical center support NCD to include but not limited to: Civilian Personnel Management, Logistics, Contracting, Resource Management, and Information Management. Additionally, the Wellness Services provides nutrition counseling services for outpatients at WRAMC; the Pediatric Outpatient Clinic contracts a dietitian to provide nutrition services to outpatient pediatric patients and for the Pediatric Intensive Care Unit: Endocrinology contracts a dietitian to provide nutrition services to diabetic outpatients; and the Pharmacy Service makes available a pharmacist for the Nutrition Support Team.

b. Sources of support services: The majority of support services are provided from within WRAMC as active duty military or Department of the Army civilian employees. Exceptions include contracted dietitians in the Wellness Services, in the Pediatric Outpatient Clinic and in the Endocrinology Clinic. Additionally, a small but increasing number of food service employees are contract rather than government employees.

c. Support services provided: A registered dietitian supports a clinic on Capitol Hill for employees in the Senate and House of Representatives, as needed. Support is also provided to Fort Meade for the Army Weight Control Program. Professional and para-professional staff conduct health promotion and community nutrition activities throughout the year. Dietitians, dietetic interns, and dietetic technicians provide approximately 1300 nutrition consultations per month for in- and out-patients at WRAMC. The NCD serves approximately 5000 meals on a weekday. Patient tray service includes meals three times a day, seven days a week, as well as alternate feeding modalities and supplemental feedings. Additionally, food services are provided for staff and visitors, and a night meal is available for staff and patients. As the nutrition care consultant for the North Atlantic Regional Medical Command, the NCD provides support to four MEDDACs, four free-standing ambulatory care clinics, and one medical center. This support includes expertise and assistance in administrative, clinical, and training aspects.

d. Clinical necessity of support services: Medical nutrition therapy plays an important role in promoting optimal patient care and producing positive health outcomes. Registered dietitians provide comprehensive nutrition services that have been shown to improve patient outcomes for many disease states. Studies have also shown that dietary counseling decreases the patient's hospital length of stay and therefore reduces health care costs.

e. Timeliness of support services: A registered dietitian is available onsite Monday-Friday, 0730-1900; Saturday, 0730-1630; and telephonically via long-range beeper 24 hours a day, 7 days a week.

6. Availability of Necessary Staff.

The TDA for NCD reflects 12 officers (1 in Wellness Program), 22 enlisted, and 140 civilians. Currently NCD is staffed with 11 officers (1 in Wellness Program), 21 enlisted and 133 civilians. The employees are assigned to one of three divisions within NCD: Production and Service; Clinical Dietetics and Research; and Education and Training. The staff includes 15 registered dietitians and 5 dietetic interns. Additionally, the 2290th US Army Reserve Hospital augments coverage on weekends and during their annual training.

7. Recognized Standards or Guidelines for Practice.

a. All dietitians on staff are registered dietitians (RDs) and are credentialed through the WRAMC Credentials Committee.

b. The approved diet manual is the American Dietetic Association's *Manual of Clinical Dietetics,* 6th edition, 2000.

8. Methods Used to Assess and Meet Patient Care Needs.

a. Departmental Performance Improvement Plan: Copy available through the NCD and WRAMC Clinical Performance Improvement Office.

b. Satisfaction Surveys: Surveys conducted quarterly in the dining hall and on patient wards.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF OB/GYN
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The WRAMC Department of OB/GYN provides general and specialized gynecologic services to female patients of all ages. Obstetric services are provided by National Naval Medical Command; however, obstetric patients with acute problems who present to the clinic will be seen and referred to NNMC as appropriate. General gynecologic services include routine screening evaluations and primary care for women. Specialized services include urogynecology, oncology, and evaluation of any and all gynecologic problems.

2. Types and Ages of Patients Served.

The Walter Reed Department of Obstetrics and Gynecology is the referral center for gynecology for military hospitals in Europe and on the East Coast. Inpatient and Outpatient care is provided on both primary and tertiary levels.

3. Scope and Complexity of Patient Care Needs. Patient care processes and. procedures performed in our department include evaluation and treatment of:

a. pediatric gynecologic problems
b. abnormal genital bleeding
c. abnormal PAP smears
d. endocrine disorders
e. infertility
f. endometriosis and pelvic pain
g. miscarriage
h. sexually transmitted diseases
i. sexual assault
j. breast disorders
k. gynecologic neoplasms
l. pelvic floor dysfunction
m. genito-urinary tract fistulae
n. uterine leiomyoma

4. Extent to Which the Level of Care or Service Provided Meets the Patient's Needs.

The mechanisms used to identify patient needs include a brief interview by the screening nurse and the interview by the provider seeing the patient. A Board-Certified staff is available at all times for consultation and review of records to assess gynecologic patient needs. Phone consultation is available from the chief resident when patients contact the clinic by phone. If our department is unable to meet the patient's needs, patients are referred to other departments within the hospital using a consultation form and a phone call to that department when necessary. Since WRAMC is the referral center, patients with gynecologic problems are evaluated entirely within the department; patients are referred only for support services, or for non-gynecologic reasons.

5. The Appropriateness, Clinical Necessity, and Timeliness of Support Services.

These services are available within WRAMC and provide essential and timely service to aid our department in addressing patient needs.

a. Operating room
b. Radiology
c. CMS
d. Laboratory
e. Pharmacy
f. Nursing

The Department of OB-GYN supports other areas evaluating inpatients and outpatients in consultation. Our department is available for consultation from all departments within WRAMC.

6. Availability of Necessary Staff.

Staff for our department includes physician staff and support staff. The physician staff is comprised of interns and OB/GYN residents, and BC/BE staff physicians who have responsibilities and availability specific to their job description and rotation within the department. Support staff consists of civilian and military administrative clerks, and paraprofessional nursing personnel. The clinic non-commissioned officer and clinic head nurse ensure availability of, nursing assistance for patient care. Staffing variances are dealt with at a local level and are coordinated through individual supervisors. '

7. Recognized Standards or Guidelines for Practice.

The recognized standards or guidelines for practice are broad and are available through the following resources: 2002 Compendium of American College of Obstetrics and Gynecology (ACOG) Publications that includes all of the ACOG Educational and Technical Bulletins, Practice Bulletins, Committee Opinions and Practice Patterns. These references are updated yearly and are available in the office of the department Performance Improvement coordinator.

8. Assessing and Meeting Patient Care Needs.

Monthly PI meetings, review of resident records, in conjunction with a performance improvement plan are utilized to assess and meet patient care needs.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF ORTHOPAEDIC SURGERY AND REHABILITATION
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Orthopaedic Surgery and Rehabilitation (DOSR) is a multi-specialty service line providing comprehensive orthopaedic surgery and rehabilitative care. The Department provides clinical medicine and orthopaedic surgery, educates and trains future health care providers for the military, and conducts research that furthers the world's understanding of orthopaedic surgery and rehabilitative medicine. The Department is comprised of the following services: Orthopaedic Surgery, Physical Medicine and Rehabilitation, Physical Therapy, Occupational Therapy and the Orthopaedic Brace and Prosthetic Service. A description of each service follows.

a. The Orthopaedic Surgery Service offers initial and follow-up care in the General Orthopaedic Clinics as well as sub-specialized care and surgery by Board-certified Orthopaedic surgeons. Sub-specialty clinics include: shoulder, sports medicine, total joint replacement, spine, pediatrics, hand, foot and ankle, and oncology. Walter Reed Army Medical Center serves as serves as the orthopaedic tertiary referral center for the East Cost and Europe.

The Orthopaedic Surgery Service also has its own Orthotic and Prosthetic Laboratory that constructs artificial limbs and braces by prescription. In addition, the lab operates amputee, limb preservation and scoliosis clinics. The Orthotic Prosthetic Lab provides outpatient and inpatient orthotics and prosthetics. Latest state-of the-art componentry is available on all endoskeletal and exoskeletal prosthetics.

b. The Physical Medicine and Rehabilitation Service (PM&R) provides outpatient and inpatient care that utilizes an interdisciplinary team approach, which includes therapists (physical therapy and occupational therapy), nursing, social work, speech therapy, and psychiatry. Conditions commonly treated include back and neck pain, sports injuries, and musculoskeletal disorders, stroke, head/spinal cord injuries, chronic pain conditions, limb amputations and pediatric disabilities. After a complete evaluation, outpatient treatments offered include pharmacological interventions, orthotic/prosthetic prescription, joint/tendon/trigger point injections, electrodiagnostic testing, arthrocentesis, acupuncture therapy, spinal manipulation, and myofascial release modalities.

c. The Physical Therapy Service is comprised of a team of physical therapists and assistants who serve to maximize the function and relieve pain by offering comprehensive inpatient and outpatient care. Patients who are disabled by pain, disease or injury are assessed and rehabilitated according to their needs. Board-certified specialists provide neuromusculoskeletal assessment; acute and chronic pain relief, extensive pre-operative and post-operative rehabilitation and specialty programs to include geriatric and pediatric specialties. The Physical Therapy Service promotes health, fitness and injury prevention by offering classes on back care, weight loss and other wellness programs.

d. The Occupational Therapy Service provides assessment and rehabilitation designed to maximize daily life functioning, improve physical and psychosocial abilities and promote health maintenance and injury prevention. As credentialed providers, neuromusculoskeletal evaluators, and board-certified Hand Therapists, they provide services to patients with upper extremity orthopaedic impairments, and neurological and/or psychosocial disabilities. Upper extremity orthotics are fabricated by the service. Patients are evaluated for adaptive equipment to promote function. Training is provided in activities of daily living, exercise, visual-motor/perceptual skills, functional behavioral activities, and work and home safety.

2. Patients Served.

The patient population includes all active duty personnel and military retirees, their family members and eligible beneficiaries designated by the State Department. The Department provides services for beneficiaries across the nation and Europe. The PM&R services serves as a worldwide referral center for Army rehabilitative needs. The population serviced encompasses all age groups from neonate to geriatric.

3. Complexity of Patients Served.

The Department provides care in outpatient, inpatients as well as ambulatory surgical settings. Medical and functional evaluations and treatment are available for all patients as required. Referrals include patients with complex co-morbid conditions.

4. Meeting Patient Needs.

Patient's needs are identified through a comprehensive evaluation as required, a complete medical and functional history, physical examination, nature of the operative plan and preoperative preparation and from consults identified via the inpatient comprehensive screening completed on patient admission to the hospital. The patient's individual goals are also identified through Discharge Planning meetings, Pain Service meetings, interdisciplinary planning conferences and routine follow-ups (to assess both functional improvement and attainment of the rehabilitative goal.) The Operative Room committee and the DOSR Performance Improvement committee, along with non-departmental hospital committees are utilized to augment the service level quality of care assessment.

5. Support Services.

The DOSR utilizes and is supported by all the hospital ancillary services. Administrative support is provided, for example, by the Civilian Personnel Office, TRICARE, Logistics, and Headquarters. Clinical Support is provided by a wide variety of clinical services such as: Pharmacy, Radiology, Laboratory, Respiratory Therapy, Social Work, Psychiatry and Pathology. Availability of these services is provided in a timely manner when required in order to ensure high quality interdisciplinary care for the patients. Contractual agreements are available to provide administrative and clinical support services as required. The DOSR services function as main referral sites for both the inpatient and outpatient populations in the National Capital Region. The Department also supports WRAMC through participation on many hospital committees and working task groups.

6. Availability of Staff.

a. Orthopaedic Surgery: The Orthpaedic Service provides 24-hour coverage. In-house physician coverage is provided by resident staff by PGY 1,2,and 3 residents. Chief resident, Fellow and Attending Staff coverage is on-call with short response times and uniform availability buy phone or beeper. Additional staff includes: nurses, technicians and cast room technicians as well as administrative support staff.

b. Physical Medicine and Rehabilitation Service: The PM&R services has a staff of 7 Staff and 12 resident physicians, one non-commissioned officer in charge, and 3 administrative support staff. Staff members are assigned within the service, but have additional training and may be utilized in other as areas as needed due to staffing fluctuations. Two rehabilitative physicians are on-call at all times.

c. Physical Therapy: The PT service has an authorized staff of 10 therapists, 10 assistants, and one administrative support staff member. Due to workload, the PT staff has additional therapists and administrative support staff. Staff members are assigned within the service, but have additional training and may be utilized in other as areas as needed due to staffing fluctuations. Weekend PT coverage is provided for inpatients only.

d. Occupational Therapy: The OT service has an authorized staff of 5 Officers and 5 enlisted technicians, one civilian therapist and one administrative support staff. The Assistant Chief serves as Intern Director for the service. Due to the workload additional staff consists of one officer, a contract therapist and an administrative support staff member. Staff members are assigned within the service, but have additional training and may be utilized in other as areas as needed due to staffing fluctuations.

e. Orthotic and Prosthetic Lab: The O&P Lab has an authorized staff of 7 orthotists , two prosthetists, and one administrative support staff. The O&P Lab functions as the main referral site for all custom-built orthotics and prosthetics in the National Capital Region. Prefabricated and post-op devices are also issued to patients by prescription from our lab.

7. Recognized Standards or Guidelines for Practice.

The DOSR adheres to the following standards: Army Regulations, Uniform Code of Military Justice, Code of Conduct, Federal and State Law, JCAHO standards, and the Residency Review Committee. The Department also follows current professional guidelines and standards for practice as outlined by: ACGME guidelines, the American Academy of PM&R, the American Academy for Electrodiagnostic Medicine, the American Physical Therapy Association, the Occupational Therapy Association, the American Orthotic & Prosthetic Association (AOPA) and the American Board for Certification in Orthotics and Prosthetics (ABC).

8. Methods Used to Assess and Meet Patient Care Needs.

The Department assesses and meets patient needs through comprehensive evaluations, treatment, and of follow-up of care. A Performance Improvement plan for each service is in place. The plan is reviewed and updated annually. This plan is an ongoing, comprehensive, and integrated program charged with interdisciplinary prospective identification of improvement areas that assess clinical care and cost-effectiveness. The Operating Room committee is similarly designed to address problems with the operation room. Each service meets monthly to review their Performance Improvement activities and to implement actions I order to provide the highest standards of ongoing patient care.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF PATHOLOGY AND AREA LABORATORY SERVICES
WALTER REED ARMY MEDICAL CENTER

1. Mission.

a. Provide complete laboratory services to the Medical Center.

b. Act as reference and consulting laboratory for the NARMC by performing the most complex and sophisticated procedures in laboratory medicine.

c. Operate training programs for pathology residents, blood bank specialists, medical technologists and medical laboratory technicians.

d. Train for and support military readiness requirements.

e. Coordinate support for clinical investigations.

2. Scope of Services.

a. The Department of Pathology and Area Laboratory Services (DPALS) is a modern, well equipped, hospital- based laboratory offering a full range of clinical and anatomic and pathology services. The Department of Pathology and Area Laboratory Services performs routine laboratory procedures weekdays, and critical tests 24 hours per day, seven days per week.

b. The Clinical Pathology Service performs all types of medical laboratory analyses. Its sections consist of Blood Services, Chemistry, Client Services, Infectious Disease, and Rapid Response laboratories. Specialized, high complexity testing includes flow cytometry, advanced coagulation, special chemistry, toxicology, mycology virology, parasitology and tuberculosis testing. Clinical Pathology provides blood products through its transfusion service. Collection of donor blood is accomplished via both fixed facility and limited mobile blood collection means.

c. The Anatomic Pathology Service performs autopsies and provides surgical pathology, cytopathology, trans-operatory consultation and fine needle aspiration on surgical pathology and cytology specimens.

d. Support services to DPALS include information systems, logistics and administration.

e. The pathology residency and blood bank fellowship programs are open to qualified individuals in all service branches. The medical technology and medial laboratory technician programs are open to active duty Army personnel.

3. Types and Ages of Patients Served.

The Department of Pathology and Area Laboratory Services serves all active duty and retired personnel, as well qualified dependents and other authorized Department of Defense health care beneficiaries. The Department also acts as a referral laboratory for all NARMC medical treatment facilities, Veterans Administration facilities, as well as military medical units deployed abroad.

4. **Scope and Complexity of Patient Care Needs.**

DPALS provides primary patient care to both inpatients and outpatients through its phlebotomy (blood collection) services. The Client Services Section collects blood from ambulatory patients in the main laboratory; phlebotomy teams support inpatient wards for morning blood draws.

5. Extent to which Level of Care Meets Patients' Needs.

a. The Department of Pathology and Area Laboratory Services assesses patient care needs directly by conducting patient satisfaction surveys

b. Through utilization review processes, the Department monitors test menus to ensure appropriate laboratory assays are provided.

c. Through consultation with the medical staff, DPALS evaluates its critical reporting values for suitability, so health care providers can act on critical situations.

d. When an incident/occurrence is discovered which caused or has the potential for causing injury to patients or the staff, or may place the institution at risk for financial liability, the responsible individual takes immediate steps to address/correct the situation, communicate the situation and actions taken to his/ her supervisor, and document the incident using WRAMC Form 1811(*Risk Management/Quality Improvement Report*) or DA Form 4106 (*Quality Assurance/Risk Management Document*). Such reports are submitted through the DPALS PI Coordinator to the WRAMC Performance Improvement/Risk Management Advisory Group for review, trending, analysis and/or follow-up, as appropriate.

(1) When an incident/occurrence report is received in the Department, the PI Coordinator works with appropriate laboratory sections to ensure the issue is appropriately investigated, and an appropriate and timely reply is returned to the WRAMC Performance Improvement/Risk Management Advisory Group.

(2) The Department of Pathology and Area Laboratory Services tracks incident reports received and/or generated, and reports on the investigation/ resolution/ trends, as part of Service-specific quarterly PI reports.

(3) Complaints received from any area can be a source of valuable information. The Department of Pathology has established guidelines for the use of complaints for benefit in overall quality assurance/performance improvement. The Laboratory's PI Coordinator, in consultation with the appropriate Section Chief, investigates all complaints. Complaints are forwarded to the appropriate Pathology Service Chief, for review.

(4) Individual Laboratory Section Chiefs initiate utilization review studies in cases of justified adverse complaints. All complaints are documented and reported during the Services' (AP & CP) monthly performance Improvement Committee meetings.

(5) Compliments provide positive feedback to those personnel deserving praise and directly effect morale in the work place. The DPALS PI Office processes complaints and compliments during normal duty hours. The Pathologist On-Call handles these actions during other than normal duty hours.

6. Appropriateness, Clinical Necessity, and Timeliness of Support Services

a. Support Services Utilized: The Department of Pathology and Area Laboratory Services is supported by numerous administrative services, as well as various military and civilian facilities.

b. Support Service Sources: All laboratories providing referral support to DPALS meet the certification/ accreditation provisions set forth by the College of American Pathologists (CAP) and the Department of Defense Clinical Laboratory Improvement Program (CLIP). Some laboratory equipment is leased and therefore maintained by the individual vendor. The WRAMC Biomedical Maintenance Section supports the remainder of the equipment.

c. The primary function of the Laboratory is to support patient care by providing accurate and timely diagnostic testing results. Other services include support to approved research protocols and the provision of consultative services to other laboratories throughout North Atlantic Regional Medical Command.

d. Clinical Necessity and Timeliness: Diagnostic laboratory testing is an essential element for quality patient care. The Department of Pathology and Area Laboratory Services continuously evaluates its services to provide the most accurate result, in the least amount of time. The Department of Pathology and Area Laboratory Services accomplished this through its ongoing and systematic monitoring and evaluation of pre-established, outcomes-oriented performance improvement indicators that address pre-analytic, analytic and post-analytic dimensions of performance. Indicators are monitored and evaluated as system checks for process control, as well as for the purpose of identifying opportunities for improvement. PI indicators address specimen integrity and adequacy, patient satisfaction with reception/ phlebotomy, appropriateness of test requested, testing accuracy / error rates and clinical relevance, overall test turn-a round-time (TAT) / number or percentage of tests exceeding laboratory-stated TAT, test results distribution / reporting errors, critical laboratory test value notification, specimen and report trackability failures, focused quality audits, health care provider satisfaction with services, referring laboratory customer satisfaction, as well as appropriateness of test(s) requested (retrospective utilization review). Annually, each laboratory section evaluates the effectiveness of the monitoring, evaluation and problem-solving activities over the past year, and uses the information derived to identify opportunities for further improvement and make adjustments to plans for future activities.

7. Availability of Necessary Staff: Laboratory services are provided by pathologists, medical technologists, cyto-technologists, medical laboratory technicians, medical technicians and administrative personnel. Staff members work within specific sections throughout the Laboratory. However, many are trained in all laboratory disciplines; those individuals may be detailed, as needed, to accommodate workload or staffing fluctuations in other areas.

8. Recognized Standards and/or Guidelines for Practice. The Department of Pathology and Area Laboratory Services complies with all applicable federal laws, Army regulations and standards set forth by the following regulatory/oversight agencies:

a. Joint Commission on Accreditation of Health Care Organizations (JCAHO).

b. DoD Office of Clinical Laboratory Affairs (OCLA).

c. College of American Pathologists (CAP).

d. U.S. Food and Drug Administration (FDA).

e. American Association of Blood Banks (AABB).

9. Methods Used to Assess and Identify Patient Care Needs

The Department of Pathology and Area Laboratory Services follows its own departmental Performance Improvement (PI) Plan, as well as the requirements set forth in applicable Army and U. S. Department of Defense regulations. The DPALS PI Plan is continuously assessed and updated as needed; it is an integrated and comprehensive plan, which utilizes performance-based indicators and pre-determined thresholds for acceptable performance as tools for assessing and improving laboratory services. The DPALS PI Committee meets quarterly to review results from monitoring and evaluation, analyze trends, address customer services issues, initiate actions to enhance laboratory services and identify opportunities for additional performance improvement. The Department of Pathology and Area Laboratory Services PI Committee minutes are forwarded to the hospital Performance Improvement Office. Issues requiring discussion or follow-up at the hospital level are forwarded to the WRAMC Quality Outcomes Committee.

PLAN FOR THE PROVISION OF PATIENT CARE
DiLORENZO TRICARE HEALTH CLINIC
The Pentagon

1. Scope of Services.

The DiLorenzo TRICARE Health Clinic (DTHC) is a constellation of ambulatory care clinics whose staff provides general medical and minor surgical services for eligible healthcare beneficiaries throughout the National Capital Region (NCR). Care for military beneficiaries is provided at DTHC, Pentagon; DTHC, Arlington Annex; and United States Army Health Clinic (USAHC), Fort McNair. Care for federal civilian beneficiaries is provided through Civilian Employee Health Services (CEHS) at DTHC, Pentagon and eight satellite clinics. Normal duty hours are 0700 until 1600 Monday through Friday (except federal holidays). Specific services include Acute Care/Trauma, Audiology, Allergy/Immunizations/ Travel Medicine/Overseas Screenings, Cardiology, Dermatology, Flexible Sigmoidoscopy, Flight Medicine, Internal Medicine, Laboratory, Minor Surgery, Nursing, Optometry, Orthotics, Pharmacy, Physical Examinations, Physical Therapy, Podiatry, Primary Care, Radiology, and Wellness/Fit to Win. An Emergency Response Team responds to any medical or trauma emergency within the Pentagon or on the Pentagon Reservation.

2. Types and Ages of Patients Served.

Primarily, DTHC patients are healthy adults on active duty in any branch of military service. Healthcare services are also provided to retired military on a space available basis, and to eligible federal civilian employees.

3. Scope and Complexity of Patient Care Needs.

a. Patient Care Processes and Procedures. Patients utilize DTHC primarily for treatment of simple, episodic medical problems (e.g., upper respiratory infections, uncomplicated headaches, and uncomplicated musculoskeletal complaints); for minor surgical or diagnostic procedures (e.g., suturing, tissue biopsies, flexible sigmoidoscopies, and liquid nitrogen therapy); for routine immunizations (e.g., hepatitis, influenza, and tetanus toxoid); for routine screenings (e.g., Pap smears, breast examinations, eye examinations, and tuberculosis screenings); and for prescriptions. A small percentage of patients use DTHC for monitoring of chronic medical conditions (e.g., diabetes mellitus, hypercholesterolemia, and hypertension); or for obtaining emergency care. Many patients receive specialty care (e.g., cardiology, dermatology, optometry, physical therapy, and podiatry), and a number of individuals participate in Wellness/Fit to Win, a health promotion/illness prevention program which offers a plethora of wellness classes (e.g., tobacco cessation, stress management, hypertension control, nutrition, weight management, and exercise). The "Put Prevention into Practice" (PPIP) program has been initiated to increase use of clinical preventive services (screening for pre-clinical disease, increasing delivery of immunizations and chemo-prophylaxis, and counseling to motivate health behavior change).

b. Complexity: Inpatient, Outpatient, Primary, Tertiary. The DiLorenzo TRICARE Health Clinic is strictly an ambulatory care clinic; the acuity and complexity of medical problems is usually relatively low. All healthcare services are provided on an outpatient basis. Should a patient require more involved care (i.e., beyond DTHC's scope), he or she would be referred to a consultant or another clinician, or transferred to the appropriate military or civilian medical treatment facility (MTF).

4. Extent to Which the Level of Care or Service Provided Meets the Patients' Needs.

The DiLorenzo TRICARE Health Clinic enrollees are entitled to impartial access to treatment that is available and medically indicated. Four types of appointments are available for enrollees, i.e., emergent, acute (urgent), acute (non-urgent), and routine. Patients with emergent problems (e.g., chest pain, allergic reaction, severe headache, high fever) are seen immediately. Patients with acute (urgent) problems (e.g., ringworm, painful urination, injury sustained within the past 24 hours) receive "same day" appointments. Patients with acute (non-urgent) problems (e.g., musculoskeletal pain, sinus congestion without fever) are scheduled within one week, and usually seen within three days. Patients requiring routine care (e.g., physical examinations and women's health or medical screening) are seen within four weeks. Some clinics are "walk-in" (e.g., Allergy/ Immunizations/Travel Medicine); some clinics require a referral (e.g., Cardiology and Podiatry); and some clinics schedule their own appointments (i.e., Optometry, Physical Examinations, and Flight Medicine). DTHC complies with and often exceeds TRICARE access to healthcare guidelines. Because of time demands/constraints on many DTHC patients, a majority of patients with "routine" problems are seen within 24 hours.

a. **Mechanisms Used to Identify Patient Care Needs.**

(1) Self-identified needs.

(a) An enrolled patient may identify his or her own healthcare needs by calling Sierra Military Health Services Inc. @ (888) 999-5195 or contacting DTHC directly (in person or by telephone) to schedule an appointment. TRICARE Prime and Plus Primary Care appointments may be scheduled online at www.tricareonline.com.

(b) The patient is responsible for providing accurate and complete information about his or her health history, and current health problems and concerns. During appointments, clinicians usually conduct a problem-focused history and physical examination.

(i) As a component of the PPIP program, Health Enrollment Assessment Review (HEAR) questionnaires have also been provided to patients enrolling in DTHC, to identify health problems and potential risks, and thereby assist providers in planning healthcare delivery. Personal Wellness Profile (PWP) questionnaires are provided to Wellness/Fit to Win participants for the same purpose.

(ii) An automated, interactive survey "How's Your Health?" administered annually to all enrollees also assists providers in planning healthcare delivery.

(iii)The DTHC Beneficiary Screening Form (BSF) is a brief survey used to identify patients' healthcare concerns and issues that may require further assessment.

(c) Enrollees may call the "Nurse Advice Line," the TRICARE regional health care advice and education service @ (800) 308-3518 seven days a week, 24 hours a day. For emergencies, enrollees are directed to call "911" (or local emergency services number) or a Primary Care Manager (PCM). Enrollees may speak with a Registered Nurse, or may access a health information library of recorded messages.

(d) Patients are invited to complete and submit a "Beneficiary Request for Assistance or Compliment" form, or speak with the appointed Patient Representative.

(2) Needs identified by healthcare provider or other staff. Enrollees are evaluated by one or more clinical staff during their appointments; healthcare needs are assessed and prioritized, and a treatment plan is developed and initiated. To further assess needs, clinicians review (a) HEAR and PWP profiles; (b) laboratory, radiology, and other diagnostic reports; (c) Adult Preventive and Chronic Care Flowsheets (DD Form 2766); and (d) other records such as the "How's Your Health?" survey and BSF. A PCM is on call after duty hours.

b. Mechanism for Patient Referral to Another Source of Care. If a patient requires complex, comprehensive, or specialized care beyond DTHC's scope, he or she is referred to an appropriate consultant or other source of healthcare.

4. Appropriateness, Clinical Necessity, and Timeliness of Support Services.

Because DTHC's constellation of ambulatory care clinics is geographically separated from any military or civilian MTF, support services *must* be appropriate for the mission, clinically indicated, and timely.

a. Support Services Utilized. The DiLorenzo TRICARE Health Clinic utilizes support services from Administration, Civilian Personnel Office, Contracting, Garrison Environmental Office, Information Management, Laboratory, Logistics, Medical Maintenance, Radiology, Resource Management, and Pharmacy, among others.

b. Sources of Support Services. Some services are available at several clinical sites (e.g., Administration, Laboratory, Radiology, and Pharmacy). Some services are coordinated through DTHC, Pentagon (i.e., Information Management, Logistics, and Medical Maintenance), Walter Reed Army Medical Center (WRAMC) (e.g., Garrison Environmental Office for waste disposal), or other sources (e.g., Dental for sterilization of instruments). Staff in support services may be military (tri-service, both active and reserve), federal civilian, or contract.

c. Support Services Provided. The DiLorenzo TRICARE Health Clinic provides paramedical support for ceremonies in the NCR. Information Management, Logistics, and Medical Maintenance are among the other support services provided.

5. Availability of Necessary Staff.

a. To meet the healthcare needs of DTHC enrollees, an appropriate blend of clinical and ancillary staff is scheduled Monday through Friday, 0700 until 1600 (except federal holidays). A Registered Nurse is accessible through the "Nurse Advice Line" @ (800) 308-3518 seven days a week, 24 hours a day. A PCM is on call after duty hours.

b. The clinical staff includes primary care physicians (i.e., general medical officers, family practice physicians, and internists), mid-level providers (nurse practitioners and physician assistants), specialists (e.g., optometrist, podiatrist, cardiologist, dermatologist, flight surgeon, radiologist, and physical therapist), and nurses, as well as medical technicians and specialists. Clinical staff may be military (tri-service, both active and reserve), federal civilian, or contract. To ensure safe patient care at all times and under all circumstances, DTHC complies with the use of the Automated Staffing Assessment Model (ASAM), an Army Medical Command (MEDCOM) mandated manpower determination tool. Automated Staffing Assessment Model converts ambulatory workload and productivity factors into a mathematical formula yielding number of providers and support staff earned.

c. Staffing variances may occur as a result of military absences, leaves, separations/terminations, and other contingencies. When variances are anticipated, providers from WRAMC and/or the Reserve components may augment DTHC staff. Unanticipated variances are managed through a pro-active cross-training program. Staffing is adjusted during "peak" months, i.e., October and November, and January through March.

7. Recognized Standards and Guidelines of Practice.

The DiLorenzo TRICARE Health Clinic clinicians adhere to professional practice standards, e.g., those of professional associations such as the American Medical Association (AMA) and American Nurses Association (ANA), and professional academies, colleges, or societies. Other recognized guidelines of practice include applicable military directives, federal and state laws (including licensure, certification, and continuing education requirements), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, North Atlantic Regional Medical Command (NARMC) clinical practice guidelines, codes of ethics, and established protocols and standard operating procedures. Clinical competencies are verified and documented. Professional (i.e., provider) staff is credentialed through WRAMC.

8. Assessing and Meeting Patient Care Needs.

Needs may be identified by DTHC enrollees and/or healthcare providers and other staff. Staff has proven knowledgeable, skilled, and conscientious in assessing, prioritizing, and meeting patient care needs. To provide exemplary, state-of-the-art, individualized healthcare to patients, DTHC has instituted a program that encompasses quality assurance, risk management, and performance improvement processes. This multi-faceted interdisciplinary program includes a number of components to ensure quality and continuity of care (e.g., initiation of protocol-based management of healthcare problems, review of clinical records for protocol-based care and documentation, implementation of PPIP tenets, and clinical staff meetings to discuss quality of care issues).

Acronyms

AMA - American Medical Association
ANA - American Nurses Association
BSF - Beneficiary Screening Form
CEHS - Civilian Employee Health Service
DD - Department of Defense
DTHC - DiLorenzo TRICARE Health Clinic
HEAR - Health Enrollment Assessment Review
JCAHO - Joint Commission on Accreditation of Healthcare Organizations
MEDCOM - Medical Command
MTF - Medical Treatment Facility
NARMC - North Atlantic Regional Medical Command
NCR - National Capital Region
PCM - Patient Care Manager
PCS - Permanent Change of Station
PPIP - Put Prevention into Practice
PWP - Personal Wellness Profile
TDY - Temporary Duty
USAHC - United States Army Health Clinic
WRAMC - Walter Reed Army Medical Center

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF PHARMACY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

a. The Department of Pharmacy is a contemporary hospital pharmacy offering sound, well balanced, and innovative pharmaceutical services. It is organized with main inpatient pharmacy, a critical care/anesthesia/operating room satellite pharmacy, clinical pharmacy service, and a main ambulatory care pharmacy. The major functions of the Department of Pharmacy include preparation and dispensing of medication, distribution and control of medication, and provision of clinical pharmacy services. Logistical and administrative support for all pharmacies is provided by pharmacy supply service. Pharmaceutical services are provided 24 hours a day, 7 days a week. Inpatient pharmacy service offers unit dose drug distribution and complete sterile products services to all nursing units. Sterile products include all intravenous fluids with additives and such specialized fluids as total pareteral nutrition solutions, cardioplegia, and kidney perfusion solutions.

b. Clinical pharmacy programs include Hematology/Oncology, Nuclear Medicine, Internal Medicine, Critical Care Medicine, Anti-Coagulation, Medication Outcomes, Maintenance Medication Refills, and Infectious Disease. Department of Pharmacy is also represented on the Nutrition Support team.

2. Types and Ages of Patients Serviced.

The service population includes patients in ages ranging from neonate to geriatric. The patient population includes patients with the full range of diagnoses treated at WRAMC.

3. Complexities of Patient Care Needs.

Primary patient care needs are met by the Department of Pharmacy on both an inpatient and outpatient basis. Inpatient pharmacy offers unit dose drug distribution and complete sterile products services to all nursing units. Ambulatory Care pharmacy processes and fills prescription written by in-house providers and other military physicians, as well as civilian physicians from non-military facilities and clinics.

4. Extent to Which the Level of Care Meets Patient Need:

a. Patient needs are identified through periodic patient satisfaction surveys, as well as through the Pharmacy and Therapeutics Committee (PTC). The PTC provides local control and evaluation procedures in order to ensure that only the most efficacious and economical therapeutic agents for our specific patient population are accepted for use in the medical facility. The PTC sets local prescribing policies and selects the best agents based on sound clinical evidence without unnecessary duplication. A formulary, which is reviewed and revised yearly, is available on CHCS and the hospital WEB site, and educational programs are proposed to ensure rational drug use. The Department of Pharmacy meets regularly with members of the other armed services (Air Force, Navy) within the National Capital Area. This group attempts to standardize the prescribing policies and medications stocked in all of the area facilities with an objective of enhancing continuity of patient care.

b. Outpatient prescriptions written by a provider in the civilian sector are not honored if the medication is not on the hospital's formulary. In this instance, patients are directed to have the prescription filled at a retail pharmacy or National Mail Order Pharmacy (NMOP).

5. Appropriateness/clinical necessity/timeliness of support services provided directly by the department or through referral.

a. Support Services Utilized. The department of Pharmacy is supported by numerous administrative services throughout the Medical Center. The primary support service is the Prime Vendor, which works with pharmacy to ensure the availability of the highest quality pharmaceuticals for our patients.

b. Support Service Source(s). Additional personnel support for the Department of Pharmacy is provided by a contract service. Pharmacy equipment is either maintained by civilian companies under maintenance contracts or is supported by medical maintenance.

c. Support Services Provided.

(1)The Department of Pharmacy provides a myriad of support services to the hospital, to include the inpatient and outpatient functions. The supply/support service also stocks and checks the contents of emergency medication (Crash) carts, maintains an adequate supply of emergency drugs, handles drug recalls, and provides storage and other requirements related to investigational drugs.

(2) The Clinical Pharmacy Service staffs and operates a drug information center that answers questions for physicians, nurses, and other health care providers. The Clinical Pharmacy staff also develops drug monographs, participates in drug use review, publishes a therapeutics newsletter, collects and evaluates adverse drug reactions (ADRs), collects, evaluates and monitors drug error near misses, and provides educational in-services for physician, nursing, and pharmacy staff members. The Clinical Pharmacy staff also provides pharmacokinetics counseling, patient care rounds, and nutrition support consultations throughout the hospital.

(3) The Hematology/Oncology Pharmacy Service and the Nuclear Pharmacy Service provide numerous support services to their respective departments in addition to the support they provide by dispensing cytotoxic medications and radiopharmacuticals.

d. Clinical Necessity and Timeliness: The support services the Department of Pharmacy provides are integrated into almost every facet of hospital operations. Pharmacy personnel provide this support in timely and accurate fashion every day to ensure the highest quality and continuity of patient care.

6. Availability of Necessary Staff.

Pharmaceutical services are provided 24 hours a day, 7 days a week, by a staff of 10 commissioned pharmacy officers, 35 civilian service pharmacists, 23 civil service pharmacy technicians, 33 enlisted technicians, 9 contract pharmacists, 15 contract technicians and 1 secretary. Staff members are assigned to specific areas within the department, but have additional training and may be utilized in other areas, as needed due to staff fluctuations. In accordance with JCAHO guidance regarding the assessment of indirect caregiver staffing effectiveness, inpatient pharmacy staffing human resource indicator data will be assessed for its relationship to patient related clinical indicator data. Specifically, inpatient pharmacy skill mix data will be evaluated for its relationship to inpatient pharmacy medication dispensing errors. Pharmacy staffing and clinical indicator data will be reported at the Pharmacy Quality Improvemnet/Quality Assurance meeting and the Executive Committee of the Medical and Administrative Staff.

7. Recognized standards or guidelines for practice.

The Department of Pharmacy follows AR 40-3, Federal laws, JCAHO standards and current professional guidelines and standards for practice.

8. Methods used to assess and meet patient care needs.

a. The Department of Pharmacy has a Performance Improvement (PI) program/plan in place, which is reviewed and updated at least annually. It is a planned, systematic, ongoing, comprehensive, and integrated program. It utilizes indicators and related thresholds for evaluations. The Pharmacy Performance Improvement (PPI) committee meets at least quarterly to review indicators and data collection techniques, review collected data, analyze trends and implement corrective actions when necessary.

b. Patient satisfaction surveys are conducted periodically to assess patients' needs and rectify real or perceived shortcomings.

PLAN FOR THE PROVISION OF PATIENT CARE
PREVENTIVE MEDICINE SERVICE
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

a. The mission of the Preventive Medicine Service is to provide for public health and occupational health programs in accordance with (IAW) AR 40-5 for the Walter Reed Army Medical Center (WRAMC) community and the MEDCEN Health Service Area of the District of Columbia, Prince Georges and Montgomery Counties, MD and Arlington and Fairfax Counties, VA. In addition, the Preventive Medicine Service serves as a training site for Occupational and Preventive Medicine residents and provides consultation to the North Atlantic Regional Medical Command (NARMC) on preventive medicine issues.

b. Walter Reed is a complex installation associated with the industries of health care and biomedical research. These industries have unique and varied workplace hazards such as: infectious agents, chemical agents, hazardous medications and waste, workplace allergens and deleterious noise levels. The Preventive Medicine Service identifies, protects, ensures preventive measures and instills health promotion to this highly diverse community. Direct patient care is provided by the Occupational Health Section and the Community Health Nursing Section of the Preventive Medicine Service.

c. Occupational Health Section (OHC).

(1) The OHC works with employee supervisors, Industrial Hygiene and Safety personnel to identify exposures, if any, to the above-mentioned agents or others not listed and to prevent any adverse health effects from employment. Focus is on the promotion, protection, and restoration of workers health within a safe and healthy work environment.

(2) A full spectrum of outpatient Occupational Health services is provided to employees. The OHS sees between seven hundred to over one thousand employees monthly for a wide variety of services to include: occupational injury/illness/exposure evaluations, and limited treatment, return to work evaluations for civilian employees, inprocessing or pre-appointment screenings with physical examinations, birth month annual review screenings, and medical surveillance examinations for groups identified to have potential work related exposure, fitness for duty examinations, and health education.

d. Army Community Health Nursing Section:

(1) The Army Community Health Nurses (ACHN) provide nursing services in the office, unit setting, hospital ward, and Child Development Center aimed at promoting health and decreasing preventable morbidity and mortality. Services include; epidemiology and disease control, discharge planning and case management, health promotion, and maternal/child services.

(2) Epidemiology and disease control is concerned with the identification, evaluation, control, and reporting of communicable diseases and other conditions of public health and command significance.

(3) Health education and health promotion are provided to meet the diverse health care needs of beneficiaries.

(4) The ACHN office conducts monthly health inspections of the Child and Youth Services Programs. Health education classes are provided to center caregivers on medication administration, communicable disease control and special needs children.

2. Types and Ages of Patient's Served.

a. Occupational Health Clinic: The OHC provides direct care, counseling, health screening and consultative services for all employees of Walter Reed Installation. This comprises over six thousand (6,000) men and women ranging in age from the late teens to octogenarians. The OHC provides services to military and civilian employees as well as Red Cross volunteers. Further, the Chief, Occupational Health Clinic serves as a consultant for Occupational Medicine issues for the entire North Atlantic Regional Medical Command.

b. Army Community Health Nursing Section: The ACHN patient population includes approximately 100,000 active duty, retired military and family members. This population encompasses all age groups.

3. Complexity of Patient Care Needs.

Preventive care services are offered to all beneficiaries ranging from individual and group counseling sessions, preventive care classes, to managing the coordination of complex medical care for patients.

4. Extent to Which Level of Care Meets Patient Needs.

a. Occupational Health Section: Clients' needs are identified through random, ongoing satisfaction surveys as well as monthly performance improvement meetings. Staff schedules have been arranged to extend operational clinic hours to the maximum extent possible and provide access for all employees on various shifts. If employees work at outlying locations, arrangements can be made for screening/testing to be done at those sites as available.

b. Army Community Health Nursing Section: Patients' needs are identified by referral from health care providers for follow-up for communicable disease. Health education and health promotion patients are referred by health care providers or are self-referred.

5. Appropriateness/ clinical necessity / timeliness of support services provided directly by the department or through referral.

a. Occupational Health Clinic staff supports managers and employees through the following services: fitness for duty evaluations, return to work evaluations, providing medical documentation review, occupational injury/illness exposure evaluations, and limited treatment performance of routine medical surveillance examinations as well as post- exposure medical assessments, worksite visits related to safety issues, pre-employment and inprocessing screening and annual immunization reviews. The OHC staff works with Infection Control Service and the Community Health Nursing Section in evaluation and follow up of infectious disease exposures. The clinic provides initial and annual immunization screening for Red Cross volunteers and works with the Federal Employees' Compensation Act (FECA) Administrator regarding evaluation and medical documentation relating to workers compensation cases.

(1) **Clinical Appropriateness and Necessity**: The support services provided by the OHC are integral to the employees of this installation in ensuring a safe work environment as well as to the installation itself to ensure compliance with Occupational Safety and Health Administration (OSHA) guidelines. The OHC emphasizes prevention of occupational injuries, illnesses and exposures and the early detection of potential untoward effects from worksite hazards.

(2) **Timeliness**: The OHC staff provide all services in a timely and accurate manner. Injuries or accidents occurring during non-operational clinic hours may be treated initially through the Emergency Room if severe and followed up through the OHC.

(3) **Support Services Utilized**: The OHC is supported by virtually all departments within the Walter Reed Installation. Coordination with the Industrial Hygiene Section and the Safety Office are key in identifying and preventing worksite hazards. Cooperation with the Infection Control Service and the Allergy/Immunology Clinic are essential in identifying and preventing spread of infectious diseases. The Emergency room provides initial evaluation and treatment for potentially severe injuries, illnesses or exposures. Referrals are made to various other clinics within the facility to restore or maintain employee health.

b. Army Community Health Nursing Section

(1) **Support Services Provided**: The ACHN provides support for the Child Development Services DY providing periodic inspections, teaching medication administration, classes for child care providers, and acting as the health consultant. The Community Health Nurses also support training programs for student nurses from Georgetown University and the University of the District of Columbia.

(2) **Clinical Necessity and Timeliness**: The support services provided by the ACHN are integral to the clinical operations of the Family Health Center, Infectious Disease Clinic, and all services identifying patients with communicable disease or complex care requiring discharge planning or case management.

(3) **Support Services Utilized**: The ACHN is supported by numerous administrative services throughout the hospital and installation including clinical, (i.e., pulmonary, immunization, allergy, Family Health Center, pediatrics, social work, laboratory, pharmacy, nursing) as well as administrative services from contracting to logistics and community services such as Morale, Welfare and Recreation and Army Community Services. Community Health also relies heavily on services provided by outside agencies such as the U.S. Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Grounds, MD as well as the Office for Prevention and Health Services Assessment, Brooks Air Force Base, TX.

6. Availability of Necessary Staff.

a. Occupational Health Clinic

(1) Occupational Health services are provided Monday through Friday (with the exception of federal holidays) during the hours of 0700-1600. Staff includes the Chief, OHC, who is a military Occupational Medicine physician, a civilian physician, a civilian physician's assistant, two civilian Occupational Health nurses (one being the nursing supervisor) and an administrative assistant. A contract registered nurse or practical nurse and part-time data entry person are also utilized to accomplish the mission as funding permits.

b. Army Community Health Nursing Section: The ACHN Section is routinely available during normal duty hours, 5 days a week. Staff members are assigned to specific areas within the section but many are cross-trained to provide coverage to other areas when personnel shortages arise.

7. Recognized Standards or Guidelines for Practice.

a. Occupational Health Section: The OHS follows AR 40-5 Preventive Medicine, Federal laws, and OSHA standards and current professional guidelines and standards of practice.

b. Army Community Health Nursing Section: The Community Health Nurses follow the guidelines in AR 40-5 Preventive Medicine; the American Nurses Association Standards of Practice; and the Case Management Society of America Standards of Practice of Case Management.

8. Methods Used to Assess and Meet Patient Care Needs.

a. Occupational Health Clinic: The OHC, in conjunction with the Preventive Medicine Service, has a Performance Improvement Program in place that reviews patient care parameters on a monthly basis. Occupational Health services performance improvement is a planned, comprehensive and integrated program that utilizes "indicators" and related "thresholds" for evaluation. In addition, client satisfaction surveys are conducted periodically in the clinic to assess client needs and to correct shortcomings.

b. Army Community Health Nursing Section: The Preventive Medicine Service has a performance improvement program that reviews programs on a monthly basis. Community Health Nursing monitors patient outcomes, compliance with appointments, and periodic patient satisfaction surveys on a regular basis.

PLAN FOR THE PROVISION OF CARE
DEPARTMENT OF PSYCHIATRY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Psychiatry provides health care to patients of all ages and diagnostic categories throughout the Walter Reed Health Care System and through worldwide referrals. The Department offers all psychiatric services except chronic inpatient care and residential treatment and is comprised of five clinical services, each with very unique missions.

2. Types and Ages of Patients Served.

The Outpatient Psychiatry Service provides outpatient diagnosis and treatment, emergency evaluation, forensic consultation, and fitness for duty examination for adults greater than 18 years old. It is open from 0745 to 1630 Monday through Friday. Outpatients are seen in this clinic on a space-available basis and include (in order of priority) active duty military personnel, TRICARE Prime patients, TRICARE Extra and Standard, Department of Defense designees and Medicare. Patients are evaluated by residents with staff supervision or by staff members, and treatment plans are prepared. Various options are provided according to individual requirements to include brief psychotherapy, couples therapy, group therapy, long-term psychotherapy, diagnostic triage and referral, command-directed administrative and forensic evaluation, consultation to primary care, medical and surgical clinics, pharmacotherapy, referral for electro convulsive therapy, and emergency evaluation. Patients are screened by evaluation of the written consultation or by telephone. Appointments are made within one to two weeks for routine visits. Emergency visits are seen immediately. Most patients can be treated in this clinic; however, emergent and unstable cases are sent to our Inpatient Psychiatry Ward. If services are not available, TRICARE network referrals are made. Patients may also be referred to Social Work, Community Counseling Center for drug and alcohol treatment, or Psychology for specialized care. Support services are obtained from other medical services to include the emergency department, medicine, and neurology. Also utilized are laboratory, pharmacy, and radiology support. The clinic staff includes 3 military psychiatrists, 2 civilian psychiatrists, 2 social worker-psychotherapists, 2 clinical psychologists, one psychiatric clinical nurse specialist, 5 psychiatry residents and consultants. Administrative staff includes a secretary, a social science analyst and 2 medical records clerks. Staffs are available Monday through Friday from 0745 to 1630, and on some evening until 1800 for therapy groups. Patients are assessed using clinical interview, psychological testing (as required), laboratory evaluation, review of available records, and consultation with other specialists.

Diagnoses are made in accordance with criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, published by the American Psychiatric Association. The clinic does not utilize formal treatment guidelines. Outpatient Psychiatry has an extensive Performance Improvement Plan looking at administrative, treatment, diagnostic, and medication issues. Staff physicians supervise all resident cases.

The Psychiatry Consultation Liaison Service (PCLS) is a multidisciplinary evaluation and treatment service. The mission of PCLS is to provide sub-specialty evaluation and treatment, focusing primarily on adult patients with medical and surgical illnesses who also need mental health care. Typical services (not inclusive) include evaluations of patients with somatoform spectrum disorders, delirium, dementia, depression, anxiety, pain, competency and psychiatric emergencies. Treatment of these patients with pharmacological, psychological approaches (to include individual, group, family supportive, hypnotic and amytal intervention) occurs. The service is open from 0745-1630 Monday through Friday with resident and staff on-call backup after hours and on weekends. PCLS serves eligible beneficiaries who are adult (greater than 18 years of age), WRAMC inpatients and outpatients. Patients' needs are identified by primary care clinicians (in or outpatient health care provider, typically medical-surgical) via telephone or SF513.

All inpatients are seen either the same day or within 72 hours (typically 24-48 hours). Outpatients with specialty needs are seen in the next available appointment, typically within two weeks, unless deemed more urgent by the consultee. If a specific provider has been requested, an outpatient occasionally may wait longer if that provider is unavailable. Consultations are typically first evaluated or screened by a 4th year psychiatry resident or by a PCLS fellow. All cases are supervised and seen with a staff prior to formal recommendations and implementation of a treatment plan. Clinical necessity and timeliness is determined by direct contact with the consulting clinician, personally or via telephone. The consulting provider may also indicate acuity on the SF513, (Consultation Sheet). Interview with the patient, (family when available and when appropriate) review of available records, and a discussion with the referring providers all serve to assess the patient's needs and generate an individual treatment plan. Support services provided by PCLS include emergency evaluation; treatment of agitated, combative and suicidal inpatients; outpatient and inpatient evaluations for drug-drug interactions; supportive therapy; brief psychotherapy; mayday interviews; hypnosis; and psychiatric medical board addenda. Support services utilized by PCLS include library, laboratory, pharmacy, and radiology and other clinical services at WRAMC. Staffing includes two full time military psychiatrists {both with C-L Fellowship training and one with training in Geriatric Psychiatry, one civilian psychiatrist with geriatric training, a civilian clinical medical psychologist with specialty training, a civilian substance abuse social worker, a psychiatric nurse practitioner and a psychiatry geriatric fellow. The staff provides training each rotation for up to four third-year medical students, one or two fourth-year medical students, one or two fourth-year psychiatric residents, one or two psychiatry or neurology interns, and one geriatric psychiatry fellow. The service has received ABPN approval for a geriatric psychiatry fellowship.

Additionally, PCLS provides didactic training to Internal Medicine, Anesthesia, Neurology and Physical Medicine residents and staff. Standards and guidelines for practice are the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Other parameters for treatment are culled from the current literature, particularly the American Journal of Psychiatry and Psychosomatics. The PCLS Performance Improvement Plan and on-going monitors can be found in the PCLS Standard Operating Procedures (Mar 00). Continuous assessment is accomplished via quarterly monitoring to the Department of Psychiatry Performance Improvement Committee.

The Child and Adolescent Psychiatry Service (CAPS) provides outpatient direct and consultative services in child and adolescent psychiatry; medical psychiatric consultation to pediatric patients, telepsychiatry and community support. It also provides inpatient psychiatric assessment and treatment through the Adolescent Inpatient Unit at Bethesda. CAPS generally serve patients from birth through the age of 18, and the parents of these patients. CAPS provides services of varying complexity including outpatient emergency assessment and intervention services, routine assessment, psychological testing, art therapy evaluations, short and long term individual and family therapy evaluations, short and long term individual and family therapy, psychopharmacotherapy, consultation to pediatric patients, as well as consultation to schools and CDCs.

Patient care needs are identified through initial clinical intake assessments and subsequent clinical evaluations, leading to multi-disciplinary treatment plans. Patients are sometimes referred to the Fort Belvoir or the National Naval Medical Center's Child Psychiatry Clinics, and to TRICARE network providers when the patient's family has opted for TRICARE Standard or Extra programs and space is not available to WRAMC. The Adolescent Inpatient Unit refers patients upon discharge to outpatient clinics at Walter Reed Army Medical Center and Fort Belvoir, and to other TRICARE providers. CAPS, utilizes the support services of Psychology and Social Work, Exception Family Member Program, and the mental agencies of the Army, Navy, and Air Force in the National Capital Area. CAPS utilize the support of laboratory, pharmacy, and radiology services. CAPS provide support services through medical psychiatric consultation to pediatric inpatients and outpatients as well as through psychiatric assessment and appropriate follow-up of patients referred by Social Work, Psychology, or Exceptional Family Member Program.

During duty hours, the urgency and extent of services needed are determined by telephone or in person. If there is any indication of risk, the patient is referred to an emergency intake clinician and seen immediately. After duty hours, the Psychiatrist on Duty provides coverage. Non- emergent patients are contacted within 48 hours and normally given an appointment with 4 weeks.

The Child and Adolescent Psychiatry Service staff consists of five Board-Certified/Board-Eligible Child and Adolescent Psychiatrists and one Ph.D. (FTE), Clinical Psychologist, and two full-time and one part-time Licensed Clinical Psychiatric Social Workers. This staff is responsible for the training of eight Child and Adolescent Psychiatry Fellows and four Social Work Fellows. Administrative staff includes one secretary and two medical clerks. Clinical services are provided in accordance with DOD guidelines. The Child and Adolescent Psychiatry Service has a fully developed Performance Improvement Plan and carries on an active Performance Improvement process with service-level monthly reviews as well as participation in the Department Performance Improvement Committee.

The Inpatient Psychiatry Service is a 34-bed acute inpatient tertiary care psychiatric unit located in the main hospital building providing general adult (18 years or older) inpatient psychiatric evaluation and treatment of conditions delineated in the DSM-IV. Two broad categories of patients are treated: (1) the active duty and (2) the non-active duty. All admitted psychiatric patients are voluntary. If the active duty's hospitalization is involuntary, DOD Directive 6490.1 and the DOD Instruction 6490.4 are followed. Less than one patient a month requires assessment for continued psychiatric hospitalization against a serviceman's consent. All involuntary non-active duty patients who require psychiatric hospitalization are transferred to a Washington DC hospital with a civil commitment authority.

This also occurs less than once a month. Due to limited capacity and unpredictable active duty referrals from OCONUS facilities, from time to time the non-active duty eligible patients are transferred to a network civilian hospital for psychiatric care with a statement of non-availability issued by our institution.

Common indications for a referral for inpatient hospitalizations are suicidal and/or homicidal risk/behavior, acute psychosis, and conditions that cannot be safely handled as an outpatient. Sometimes, military unique personnel issues in addition to psychiatric illness require extended hospital stays. The referral base is predominantly from the National Capital Area but another essential mission is to serve as the tertiary referral center for the servicemen and servicewomen serving the nation throughout the world. The unit does not have experimental protocols.

Rather, the service utilizes traditional inpatient psychiatric therapeutic interventions such as environmental removal from a difficult situation, pharmacotherapy, cognitive-behavioral interventions, and non- regressive dynamic oriented crisis intervention. Special treatment procedures include voluntary electro convulsive therapy and use of restraints when other less invasive methods fail. Electro convulsive therapy is performed in the post-anesthesia care unit following the policies set forth for general anesthesia.

Patients presenting and identified problems are identified and discussed by the multidisciplinary team consisting of psychiatrist, psychiatry resident/intern, nursing, social work, occupational therapist, substance abuse counselor, recreation therapist and art therapist. Medical and Surgical consultations, including diagnostic laboratory and imaging capabilities are available and utilized as clinically indicated. Those cases where a suspicion of maltreatment exists, the case is referred to our FACMT for assessment. All patients have follow up appointments to an appropriate level of care depending upon illness.

Individuals with substance abuse/dependence illnesses are referred to more definitive outpatient and inpatient addiction programs such as the intensive outpatient program at Malcolm Grove Medical Center or the inpatient rehabilitation program at Portsmouth Naval Hospital.

Active duty and civilian psychiatric care personnel work on the unit. They include psychiatrists, registered nurses, psychiatric residents and interns, a psychologist, social workers, occupational therapists, art therapists, a recreational therapist, a substance abuse counselor, psychiatric technicians, medical records technicians, medical records transcriber, and a secretary. The civilian work force includes general service (GS), contract, and temporary hire. The contract hires are generally nursing personnel when workload acuity exceeds the nursing staffing.

The standards and guidelines for psychiatric practice are based on American Psychiatric Association's Practice Guidelines, standards textbooks, journal articles, consultants, consensus among credentialed practitioners, etc. Several performance improvement projects are in existence. The service has been tracking all restraint use on the unit (less than one restraint per month) to ensure compliance with JCAHO standards. Performance Improvement also tracks contraband on the unit, distributes a patient satisfaction survey, and works to improve and streamline the medical evaluation board process.

Psychiatry Continuum of Care Service (PCCS) is a newly formed service in the Department of Psychiatry. It encompasses the Adult Psychiatric Partial Hospitalization Program and also provides services to psychiatric patients in the Medical Holding Company.

The Adult Psychiatric Partial Hospitalization Program (APPHP) provides a structured program for adult patients (age 18 and above) in need of intensive, time limited outpatient treatment. Program emphasis is on strengthening supports; improving coping skills, and decreasing acute symptoms. Treatment groups offered during the APPHP include: Group Psychotherapy, Stress Management, Medication and Diagnosis Teaching, Life Skills, Relapse Prevention, Coping with Illness, Coping with Sociality, Leisure Education, Communication Skills, Discharge Planning, Anger Management, Addiction Education, Building Positive Relationships, Feelings Exploration, Creative Coping, Social Skills, Career Planning, Recovery from Abuse, Relaxation, Self Esteem, Mastery Experiences, Spiritual Issues, Identification of Needs, and Daily Goal Setting.

The APPHP treatment day is from 8:15 a.m.-3:15 p.m., Monday through Friday and is overseen by a multidisciplinary team consisting of Psychiatry, Nursing, Social Work, Art Therapy, Recreation Therapy, Occupational Therapy, and Addiction Medicine. The average length of stay is two weeks for most patients but is adjusted to meet the patient's individual treatment goals as needed. Each patient is assigned an individual counselor to help coordinate the patient's course of treatment and attainment of goals.

An individualized treatment plan is written for each patient, based upon the clinical and functional needs demonstrated by the patient. Patient's needs are assessed through clinical interview with the patient, discussion with the referring provider, collateral information as available and available records. Patients are referred to other medical services for support as their physical condition warrants to include: Medicine, Surgery, Neurology, Laboratory, Pharmacy, Physical therapy, Pain Clinic, Radiology and works closely with the Inpatient Psychiatry Service at Walter Reed Army Medical Center (WRAMC); the Drug and Alcohol Rehabilitation Unit at Malcolm Grow Medical Center (MGMC), and Outpatient Mental Health Clinics in the immediate and distant regions.

The Psychiatry Continuity Care Service also provides ongoing psychiatric care to those active duty members assigned to Medical Holding Company as they await the outcome of their Medical Board process.

The Psychiatry/ Forensic Service provides comprehensive medico-legal consultation and evaluation of cases involving questions of criminal and civil competency, mental responsibility, security clearance, potential for dangerousness, equivocal death, psychiatric disability, or malpractice on a worldwide basis. The service evaluates adult, adolescent, and pediatric patients. Priority is given to evaluations involving active duty service members within the North Atlantic Regional Medical Command but other active duty members, DOD civilians, and dependents may be evaluated on a space-available basis.

Providers are instructed to contact the Psychiatry/Forensic Service to schedule an evaluation, to determine whether the forensic psychiatry service is an appropriate referral source, or for assistance in finding additional forensic psychiatry resources.

The Telepsychiatry/Community Mental Health Service scope of practice is very similar to outpatient psychiatry at Walter Reed Army Medical Center. It is an outreach program that has been developed to support the outlying mental health clinics that may have a critical shortage of mental health specialists with few supports in the TRICARE network. Consultation, comprehensive mental health evaluation, treatment and referrals are provided via video teleconferencing to ensure that quality and safety are not compromised. An informed consent is obtained from every patient seen via video teleconferencing and each of them is given the option to travel to WRAMC to be seen in person. Patients are given appointments within one to two weeks. In emergent situations they are evaluated for risk at the local ER by a physician and transferred when necessary to the WRAMC inpatient psychiatry for more intensive treatment. Currently all providers doing VTC work in psychiatry are privileged both at WRAMC and the distant site.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF PSYCHOLOGY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

a. The Department of Psychology provides services in four broad areas: mental health treatment, behavioral medicine assessment and treatment, psychodiagnostic assessment and consultation, neuropsychological diagnosis and assessment, research consultation, command & organizational consultations and telemental health. Patients seen by the department are referred by inpatient psychiatry, neurology, neurosurgery, primary/care internal medicine and consultation/liaison psychiatry. Extensive outpatient services are provided in the Psychology and primary care clinics and other departments. Services provided include individual psychotherapy, marital therapy, neuropsychological assessment and health psychology that focuses on changing behaviors deleterious to health and managing chronic medical conditions to optimize patient functioning.

b. Clinical services are provided in the context of two professional training programs: the clinical psychology residency program and the clinical neuropsychology fellowship. The training programs enrich and fortify the delivery of high quality patient services.

2. Types and Ages of Patients Served.

Patients across the lifespan are served ranging in age from young children to geriatric. In broad categories, patients with psychiatric and neurologic problems are the predominant referrals. In addition, the Department provides services to individuals with a wide variety adjustment reactions to primary medical diseases and diagnoses.

3. Complexity of Patient Care Needs.

As Walter Reed Army Medical Center (WRAMC) serves as a referral center for the smaller medical centers worldwide, it is common for the Department to see patients with complex problems and uncertain diagnoses. On the inpatient psychiatry service, for example, one sees soldiers and family members who have experienced significant psychological stress. The resulting emotional disorganization must be accurately assessed and understood within that context. Similarly, neurological and neurosurgical cases are referred that require specialized techniques such as lateralization of brain language functions using intracarotid amobarbital (Wada testing). Finally, forensic evaluations of military members accused of crimes are often referred to WRAMC. Hence, while there are indeed many patients with typical disorders served in the Department, the regular referral of complicated cases necessitates a high degree of expertise in psychodiagnostic and neuropsychological assessment within the staff.

4. **Patient Care Needs.**

a. Patient care needs are established through a variety of means. Staff members attached to other services (e.g., neurosurgery, internal medicine and the breast cancer center and/or the HIV clinic) regularly attend clinical case conferences and administrative meetings that convey the requirements of patients referred to by that service. This information is returned to the Department and used for planning purposes. At the outpatient level, the Psychology Clinic uses a brief questionnaire for each patient that allows the individual clinician to quickly determine the type of services sought. Periodically, data from these questionnaires are collated to provide a picture of patient needs as a composite.

b. At present, the Department is able to provide for most patient care needs. The one exception is neuropsychological services for children under age 15 and some psychotherapeutic treatment services for children and families. In these cases, patients are typically referred to the TRICARE Office for assistance.

5. Support Services.

The Department has consultation, clinical, teaching and research relationships with many departments at WRAMC.

6. Staffing.

The Department is staffed with 10 psychologists, 4 psychology residents, 4 paraprofessionals (psychometrists) and 4 administrative staff. Three staff members are qualified as neuropsychologists. The majority of the faculty are Board-certified and/or fellowship trained. The Department is divided into three services: The Behavioral Health Clinic, Clinical Neuropsychology Service and the Health Psychology/Behavioral Medicine Service. Individuals are assigned in accordance with their specialties. Some are attached to other departments to improve efficiency and communication with regular referral sources. Psychometricists support the professional psychologists through test administration, scoring and database management.

7. Research.

The Psychology Department is very active in its research activities. The department has produced 32 papers in the past 18 months and six faculty members have been named to Fellow status in National Academies or professional societies. The department is seen as the national leader in teleneuropsychological research.

8. Recognized Standards or Guidelines for Practice.

The Department operates under the following professional practice standards published by the American Psychological Association: Specialty Standards for the Provision of Services in Clinical Psychology; Ethics and Code of Conduct; and Accreditation Manual for Psychology Internships. In addition the guidelines of the JCAHO Accreditation Manual are adhered to as is the AR 40-68, Quality Assurance Management.

9. Meeting Patient Care Needs.

The Department prepares annually a Performance Improvement Plan. A major part of the plan consists of gathering and monitoring objective data over time deemed to reflect the quality of care provided by the Department. The Department participates in the Patient Satisfaction Survey conducted annually in the Medical Center. In addition, the Department conducts its own internal survey periodically to assess issues more directly relevant to its operations and services.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF RADIOLOGY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Radiology is comprised of three services: Diagnostic Radiology, Nuclear Medicine, and Radiation Oncology. All three services provide a full range of tertiary care services and graduate training programs. The main department provides logistical and administrative support for radiological services, 24 hours a day, seven days a week.

2. Patients Served.
The patient population includes approximately 300,00 active duty military, retired military and family members of both. The hospital serves a worldwide referral center for Army medical centers and hospitals, as well as for the other military services. We are capable of providing services to all patients, regardless of age (neonate to geriatric), gender, or seriousness of illness or injury.

3. Complexity of Patient Care Needs.

The Department of Radiology meets primary patient care needs on both an impatient and outpatient basis. A complete range of diagnostic procedures is offered in both Nuclear Medicine and Diagnostic Radiology. Direct patient care and treatment are provided by the Radiation Oncology Service, Nuclear Medicine Service, Imaging Service, and by the Interventional Section of the Diagnostic Radiology Service. If we are not able to provide a service, we have existing backup agreements with civilian medical centers in the immediate area.

4. Meeting Patient's Needs.

Patient's needs are identified through periodic satisfaction surveys as well as through the Continuing Quality Improvement Plan (CQI). This evaluation process ensures that only the most efficacious examinations are recommended to hospital physicians for the specific care of our patient population and for this medical facility. The Department of Radiology also maintains TRICARE access standards for care.

5. Appropriateness of Support Services Performed.

a. We are a support service and meet all the needs of the clinical services. Support services utilized: the Directorate of Logistics Provides most of our support needs. The health Physics Office also provides support.

b. Support service source(s): We receive support for DOL directly or through a contract. Most of our technology equipment is serviced through vendor contracts.

c. Support services provided: The support services we provide are designed to meet all of the diagnostic needs of the clinical services. Radiology personnel provide this support in a timely and accurate fashion daily to ensure that highest quality and continuity of patient care.

d. Clinical necessity and timeliness: Clinical services are very dependent on quality and timely radiology support in order to properly care for their patients. The department of Radiology's support is essential to timely diagnosis of stays and treatment, which contributes to shorter lengths of stays and lowered morbidity.

6. Availability of Necessary Staff.

a. All radiological services are available 24 hours a day, seven days a week including all holidays. This is maintained with our current staffing and includes a combination of professional and technical staff. Nuclear Medicine and Radiation Oncology each maintains its own roster. Diagnostic Radiology has separate call schedules for Interventional Radiology, and Imaging Radiology.

b. A staff radiologist is available in the hospital 0700-2000 hours and a senior resident with at least 18 months of training remains in the hospital after those hours. Some services, such as MRI and CT, run 24 hours per day, necessitating three full time shifts.

7. Recognized Standards and Guidelines for Practice.

The Department of Radiology follows AR 40-2, Army Medical Treatment Facilities - General Administration , Federal laws, and JCAHO standards, The American College of Radiology standards, and current professional guidelines and standards for practice and staffing. The Department of Radiology maintains up-to-date policies and protocols.

8. Methods to Assess and Meet Patient Care Needs.

a. The Department of Radiology makes every attempt to assess and meet patient care needs by issuing hospital and department surveys. The Chief of the Department maintains an “open-door” policy so that the patients and referring physicians have easy access for commenting on the service provided.

b. The Department of Radiology has an active Performance Improvement Plan, and monthly meetings are held to discuss problems in order to prevent problems and improve our performance.

c. Patient Satisfaction Surveys are carefully reviewed so that the department is responsive to the needs and perception of patients.

PLAN FOR THE PROVISION OF PATIENT CARE
SUBSTANCE ABUSE PROGRAM
SUBSTANCE REHABILITATION SERVICE
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Substance Abuse Rehabilitation Services (SARS) is the counseling center of the Army Substance Abuse Program (ASAP) at Walter Reed Army Medical Center (WRAMC). The SARS is an outpatient substance abuse treatment center located on the second floor of Borden Pavilion, Building 6. Its services are available to all active duty personnel and Department of Army Civilians employed at WRAMC. Retirees and family members are afforded services as resources permit. Regular clinic hours are Monday through Friday from 0730-1630 hours.

2. Organization.

The Substance Abuse Rehabilitation Service is the clinical activity associates with the Army Substance Abuse Program. The SARS staff is directly responsible to the WRAMC Deputy Commander for Clinical Services (DCCS). This organizational design was established in response to DA Message 31200Z which specified that "the Clinical Director (CD) and his/her clinical staff will work for the local Medical Treatment Facility (MTF) Commander. The MTF provides the credentialing, supervision, and medical support to the clinical staff." All clinical staff on the SARS TDA are credentialed by the hospital. The SARS is directed by the Clinical Director. The Clinical Director reports to the DCCS. She coordinates directly with hospital staff for matters relating to privileging, manpower, performance improvement, and information management. The Clinical Director or his/her designees participate in hospital and installation-based interdepartmental activities such as the Performance Evaluation and Improvement Activities, Family Advocacy, Fire and Safety Committee, and the Provider Health Committee. The SARS staff coordinate closely with the Alcohol and Drug Control Officer (ADCO) and his/her staff in the provision of education, prevention, and training services and in the abstinence monitoring requirements (e.g., urinalysis and breathalyzer tests) of the program. The SARS staff also work closely with the staff of the Behavioral Health Service in the provision of care.

3. Mission.

The WRAMC Army Substance Abuse Program staff are committed to providing a caring environment in which individuals can build sober lifestyle aligned with twelve step principles and habits of effectiveness. The staff is committed to the enhancement of quality living through prevention, early identification, and individualized treatment strategies to promote wellness for individuals and their families. Comprehensive services are provided IAW Policy Memorandum (HA9700029) to promote the seamless delivery of quality care for all eligible beneficiaries that meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the patient placement criteria of the American Society of Addiction Medicine (ASAM).

4. Objectives.

The ASAP program is a manpower conservation program comprised of several functional areas to include prevention, education, identification, treatment/rehabilitation, and program evaluation. The program's objectives are:

a. To maintain the efficiency, productivity, and health of military and civilian personnel through the prevention of alcohol and other drug problems.

b. To facilitate the development and practice of healthy lifestyles.

c. To provide assistance, rehabilitation, and referral services to identified alcohol and other drug abusers.

d. To provide education, training, and consultative services to the WRAMC community of families, Commanders and supervisors, healthcare providers, and students.

e. To provide for program evaluation and research through a continuous process of Performance Improvement.

f. To ensure that adequate resources and facilities are provided to successfully and effectively accomplish the ASAP mission.

g. To ensure that all staff assigned to the ASAP are appropriately oriented, trained and experienced to effectively accomplish their mission.

6. Program Description.

a. The Army Substance Abuse Program has three basic components:
(1) Adult Outpatient Substance Abuse Treatment Services
(2) Prevention Education Training
(3) Principle-Centered Leadership Training

Adult Outpatient Substance Abuse Treatment Services.

Individuals enrolled in the SARS, an adult outpatient addictions treatment program, are provided with a thorough biopsychosocial evaluation in addition to exploring their substance use history. Based on the information derived from self-report, medical, and collateral information, diagnostic impressions are formulated and treatment recommendations are developed. The severity of the substance history guides the intensity and duration of treatment. Individuals with substance abuse diagnoses are usually enrolled for a period of approximately 3-6 months. Readiness for program completion is assessed based on demonstrated mastery of a goal-oriented personal planning and evaluation process and making substantial progress in behaviorally-defined areas or roles. Individuals with dependence diagnoses are generally enrolled for a period of nine months to one year, often with the opportunity to complete a Partial Hospitalization or residential rehabilitation program followed by aftercare. Readiness for program completion is assessed based on the solidity of their primary recovery activities and implementation of lifestyle changes that promote sober living and personal effectiveness. In addition, individuals who have attended the three-day seminar on The Seven Habits of Highly Effective People will be encouraged to utilize the personal planning and evaluation process to enhance growth in individually identified person roles and goals. There is a strong emphasis on self-directed, community-based, 12-step involvement. Completion of a written relapse prevention program is often important. All individuals in the SARS are expected to remain free of mood-altering substances. Family members are supported though brief interventions and referrals to community-based resources such as ALANON and focused family treatment services.

Prevention Education Training.

Prevention and Education Training activities are offered to Commanders, service members, supervisors and civilian employees, family members and healthcare providers throughout the WRAMC community. Educational outreach to community groups is available as well.

Principle-Centered Leadership Training.

Training in Principle-Centered Living and The Seven Habits of Highly Effective People is offered at least quarterly to enrolled patients in the ASAP and to members of the WRAMC Community. The training is used primarily in support of programs and services offered by the ASAP in the belief that it is a valuable tool in developing and maintaining health lifestyles and enhancing personal effectiveness. Members of the ASAP clinical staff trained in The Seven Habits of Highly Effective People and certified as facilitators by the Covey Leadership Center, work closely with the Alcohol and Drug Control Office staff in facilitating these training sessions.

6. Procedures.

Detailed procedures for the ASAP are contained in the clinic's Professional Service Plan and are consistent with AR 600-85 Army Substance Abuse Program. These documents are intended to guide clinical and administrative decision-making. Staff is expected to be thoroughly familiar with these procedures. All staff is expected to follow the procedures described therein. The staff is encouraged to raise questions or concerns through the Performance Evaluation and Improvement (PE & I) discussions in order to resolve inconsistencies, deal with unforeseen situations, and/or develop new or expanded guidelines to enhance clinical services.

PLAN FOR THE PROVISION OF PATIENT CARE
DEPARTMENT OF SURGERY
WALTER REED ARMY MEDICAL CENTER

1. Scope of Services.

The Department of Surgery includes 13 services, providing a full range of primary, secondary, and tertiary surgical care. A brief description of each service is included below:

Clinical Service (Training Programs)	Description
Anesthesia (Residency Training) (Certified Registered Nurse Anesthetist Training)	Provide general and regional anesthesia in 14 ORs and 6 other anesthesia sites. Oversight of post-anesthesia recover unit and Pain Service
Audiology and Speech (Audiology Fellowship)	Provision of audiologic assessment and hearing aids, consultative and rehabilitative speech services.
Cardiothoracic (Residency Training) (Cardiothoracic Perfusionist School)	Adult and pediatric cardiac and general thoracic surgery across the spectrum of surgically correctable congenital and acquired cardiothoracic disease.
Critical Care (Residency Training for Anesthesiology, Medicine, Pulmonary, and Surgery)	Surgical intensive care, unit care of critically ill adult patients from all surgical services.
General Surgery (Residency Training) (Enterostomal Therapy Training)	Care of adult and pediatric general surgical illness to include endocrine, surgical oncology, pediatric surgery, colorectal, critical care, and laparoscopic specialties.
Neurosurgery (Residency Training)	Provision of adult and pediatric care of intracranial and peripheral congenital acquired neurosurgical disease to include tumor, aneurysm, avm, shunts, and discs.
Ophthalmology (Residency Training) (Ophthalmology Technician Training)	Adult and pediatric ocular disease with the full range of specialty support to include glaucoma, retina, pediatric, and tumor.

Clinical Service (Training Programs)	Description
Oral and Maxillofacial Surgery (Residency Training)	Adult and pediatric congenital and acquired surgically correctable maxillofacial disease and injury.
Organ Transplant	The immunologic assessment of and operative management of pancreas and renal transplantation and pre and postoperative care of liver transplantation patients.
Otolaryngology (Residency Training)	Medical and surgical care of the pediatric and adult patient with head and neck cancer, otologic, swallowing, speech and reconstructive disease of the head and neck.
Plastic Surgery	Reconstructive, burn, and cosmetic surgical care of adult and pediatric patients with acquired, acute or congenital diseases.
Urology (Residency Training)	Provision of urologic care to include subspecialty care of cystoscopy, lithotripsy, oncology, infertility, pediatrics and constructive surgery.

2. Patients Served.

The general population in the National Capitol Area is 400,000 beneficiaries. Approximately 50% of the patients cared for are external from across the nation and Europe. This population encompasses all age groups to include neonates to geriatrics and all military branches including active duty patients, their dependents, retirees and their dependents.

3. Complexity of Patient Care Needs.

The Department of Surgery provides care in outpatient, inpatient, and ambulatory surgery settings. This includes the primary, secondary, and tertiary surgical care of low and high-risk patients. The referral is such that patients with complex co-morbid conditions, regardless of the complexity of surgery required are sent for care at WRAMC. Postoperative patients requiring intervention are also referred for critical care management in the Surgical Intensive Care Unit (SICU).

4. Meeting Patient's Needs.

Patients are considered for multi-disciplinary care when required through the format of interdisciplinary planning conferences and tumor boards. Preoperative conferences are common in the Department of Surgery, designed to define appropriateness of care before it is rendered to include assessment of indications for surgical treatment and nature of operative plan and preoperative preparation. The Operating Room Committee and the Performance Improvement Group of the Department of Surgery (DOS), along with non-departmental hospital committees and boards are utilized to augment the service level assessment of quality of care.

5. Support Services.

Through its services, the DOS utilizes and coordinates all hospital ancillary/support services such as Pharmacy, Radiology, Laboratory, Respiratory Therapy, and Physical Therapy in the care of surgical patients. A close working relationship exists with the Pathology Department to assure proper anatomic and laboratory interventional radiology, cardiology, pulmonary, gastroenterology, nephrology and endocrinology as well as orthopedics and gynecology, freely exist at WRAMC. Availability of this interaction and timeliness is not an issue as all of these services are provided at all times when required.

6. Availability of Necessary Staff.

The Department of Surgery provides 24 hours coverage for all its services described above on an as needed basis. In-house physician coverage is provided by resident staff by PGY 1 residents for all services and PGY 2 or 3 General Surgery and Neurosurgery. Chief Resident, Fellow and Attending Staff coverage is on-call with short response times and uniform availability by phone and beeper. Nearly 200 physicians and 200 clinical and administrative support staff are assigned to the Department of Surgery.

7. Recognized Standards or Guidelines for Practice.

The Department of Surgery adheres to Army regulations, Uniform Code of Military Justice, Code of Conduct, Federal Law, Residency Review Committee, ACGME standards, JCAHO standards, and other applicable professional guidelines and standards.

8. Methods Used to Assess and Meet Patient Care Needs.

The Department of Surgery has a Performance Improvement Group that meets monthly and is charged with multidisciplinary prospective identification of areas of improvement in access, clinical care, and cost effectiveness. The Operating Room Committee is similarly designed with this approach in mind for issues pertaining to the OR. Service level quality assurance and quality improvement programs allow attention to patient care problems at the specialty level. These are then reviewed monthly and tracked by DOS, providing an additional layer of oversight on the process.

The proponent agency of this publication is the Commander. Users are invited to send comments and suggested improvements on DA Form 2028(Recommended Changes to Publications and Blank Forms) to the Commander, Walter Reed Army Medical Center, ATTN: MCHL-CO, 6900 Georgia Avenue, N.W., Washington, D.C. 20307-5001.

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